Wirral NHS
Health Authority

The Report of the Independent Inquiry into the Care and Treatment of Paul Horrocks

Commissioned by Wirral Health Authority

Mrs Jane Mackay
Dr Rob Poole
Mr Stewart Sinclair

2001

Index

PREFACE

We were commissioned by Wirral Health Authority to undertake this Inquiry and we now present our report. It is important to make it clear that this report relates primarily to the events leading up to the tragic death of Carol Houghton and the transfer of Paul Horrocks to a secure hospital environment. We have not addressed the effectiveness of the remedial action taken subsequently.

The report is based on the written and verbal evidence given to us by those who were closely involved with Paul Horrocks prior to Carol Houghton's death. We took evidence from those involved with him since that time, and from Paul Horrocks himself. We also took evidence from past and present managers of the mental health and social services on the Wirral and from some members of staff who had not had direct contact with Paul Horrocks. Some of those who gave evidence are no longer involved in the delivery of mental health services on the Wirral. It is inevitable that recollections of events some 18 months ago varied in quality and breadth. It is also inevitable that some of those recollections varied between individuals and that we were persuaded by some accounts more than others.

We recognise that we carried out our Inquiry with the benefit of hindsight and in the knowledge that Paul Horrocks eventually committed a homicide. It is likely that some of the findings in this report were not and could not have been recognised prior to 27/12/98. Nonetheless, modern mental health services have a duty both to protect the welfare of their patients and to protect the public from harm.

As is usual in such Inquiries, our terms of reference were framed around the care and treatment of a patient in the context of their involvement with mental health services. In the case of this Inquiry, the relevant context was the Birkenhead mental health service and the management of that service. Consequently, we reviewed a wide range of issues affecting the adult mental health service in Birkenhead. We did not scrutinise adult mental health services in other sectors, nor any other aspect of mental health and community services on the Wirral.

It therefore cannot be assumed that the comments we make about the services in Birkenhead apply elsewhere in Wirral and West Cheshire Community NHS Trust. It is also some months since we took evidence and we are aware that work has continued to resolve many of the problems we identified.

Some of the problems we identified are commonly recognised in Inquiry reports, such as poor communications, failures of team working, lack of continuity of care and poor risk assessment. Others were of a more unusual kind. We found a demoralised workforce struggling with unsustainably high workloads and inadequate management support. A number of staff who gave evidence expressed considerable emotional distress over working in these conditions.

Our objective has been to identify lessons to be learned from this tragedy. We have highlighted deficiencies in the Birkenhead service which existed at the time of the tragedy. Many witnesses told us that there had been significant problems with service provision in Birkenhead and that there was ongoing work to remedy the situation. We hope our recommendations will build on the work already commenced by the Trust and the Health Authority, particularly in the areas of Consultant recruitment, strengthened management and improved communication systems and agree an action plan to take account of any residual deficiencies in Birkenhead.

Whilst there is implicit criticism of individuals in the report we do not believe that it is appropriate to blame any of those individuals. Furthermore nothing in this report should be taken to be critical of managers employed subsequent to the tragedy.

INTRODUCTION

The Inquiry Team wish to express their sympathy to the family and friends of Carol Houghton whose tragic death led to the establishment of this Inquiry. We hope that the Inquiry process will resolve some of their unanswered questions.

In the early hours of the 27 December 1998, Carol Houghton died following a severe beating by Paul Horrocks. She and Paul Horrocks had met in the July of that year. No professional person visiting Paul Horrocks ever met her. Indeed, they did not know of the violence she suffered towards the end of her life, although they did know that the relationship was "stormy".

According to Paul Horrocks, on the night of Carol's death they had been drinking and had an argument about the IRA. They ended up fighting. He hit her about the face, leaving her on the floor, and went out for a drink. He later returned home and, on finding her still lying on the floor, telephoned the police. He was arrested and later charged with Carol's murder.

On 8 June 1999 Paul Horrocks was found not guilty of murder, but guilty of manslaughter by reason of diminished responsibility. On 10 June 1999 he was transferred from prison to the Scott Clinic, Regional Secure Unit, on a Hospital Order under Section 37/41 of the Mental Health Act 1983.

Paul Horrocks had a previous history of violence as well as mental illness. In 1988 at the age of eighteen Paul Horrocks was sentenced to a Probation Order of eighteen months for criminal damage and theft. Later that year he was sentenced to six years imprisonment for aggravated burglary. During this burglary he had assaulted an elderly woman with her walking stick. She died soon after.

In 1994 Paul Horrocks was detained in hospital under Section 37 of the Mental Health Act 1983 after he had assaulted his mother, his stepfather and a police officer. Following his arrest he was diagnosed as suffering from schizophrenia.

As far as the Inquiry Team was able to ascertain, these were the only criminal convictions he had received prior to coming under the care of the psychiatric services on the Wirral.

The Terms of Reference as agreed by the Health Authority were

1. To examine all the circumstances surrounding the treatment and care of Paul Horrocks by the mental health services, in particular:
   a) the quality and scope of health care, social care and risk assessment.
   b) the appropriateness of treatment, care and supervision in respect of:
      (i) assessed health care and social care needs,
      (ii) assessed risk of potential harm to himself or others,
      (iii) any previous psychiatric history including drug and alcohol abuse,
      (vi) the number and nature of any previous court convictions.
2. The appropriateness of the professional and in service training of those involved in the care of Mr Horrocks or in the provision of services to him.
3. The extent to which Mr Horrocks' care corresponded to statutory obligations national guidance (including the Care Programme Approach, HSG(90)23/LASSL(90)11); Supervision Register HSG(94)5; Discharge Guidance HSG(94)27; Mental Health Act 1983 including Sec 136 and any local operational policies for the provision and support of mental health services.
4. The extent to which his prescribed treatment and care plans were effectively drawn up; agreed with Paul Horrocks, communicated within and between relevant agencies and his family; delivered and complied with by Paul Horrocks.
5. To examine the adequacy of the collaboration and communication between Wirral and West Cheshire Community NHS Trust, Social Services Departments, Mr Horrocks' general practitioner and any other agencies who were, or might appropriately have been, involved in his care.
6. To take into consideration the report of the Internal Inquiry undertaken by the Wirral and West Cheshire Community NHS Trust.
7. To prepare a report on the findings and make recommendations to Wirral Health Authority.

INQUIRY PROCESS

The Wirral Health Authority had an obligation to commission an independent inquiry, following the homicide, under the Department of Health guidance HSG 94/27. The purpose of such an inquiry is to establish whether there are lessons to be learned from this tragic incident and to make recommendations for the delivery of mental health services in the future.

The Inquiry was undertaken by:

Mrs Jane Mackay (Chairman), former NHS General Manager and Regional Nurse.

Dr Rob Poole, Consultant Psychiatrist.

Mr Stewart Sinclair, Social and Health Care Advisor and Trainer.

Procedure adopted by the Inquiry

1. Witnesses received a letter in advance of appearing to give evidence. This letter asked them to provide a written statement as the basis of their evidence to the Inquiry and informed them of the terms of reference and the procedure adopted by the Inquiry. It also covered the areas and matters that were to be discussed with them, and they were assured that they could raise any matter they wished which they felt might be relevant to the Inquiry.
2. Witnesses were invited to bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wished to accompany them, with the exception of another Inquiry witness. It was explained to the witnesses that although there was an expectation that the questioning would be directed towards themselves, there might be occasions when the person accompanying him/her could be asked to clarify a particular point.
3. Witnesses were not asked to affirm their evidence, but the seriousness of the proceedings was pointed out to them and we were assured that all the witnesses we saw would answer our questions in their own truthful manner.
4. Evidence was recorded and a written transcription sent to witnesses afterwards for them to sign.
5. Any points of potential criticism were put to witnesses of fact, either verbally when they first gave evidence, or in writing at a later time, and they were given a full opportunity to respond.
6. All sittings of the Inquiry were held in private. The draft report was made available to the Health Authority, for any comments as to points of fact.
7. The findings of the Inquiry and any recommendations will be made public.
8. The evidence which was submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, except insofar as it is disclosed within the body of the Inquiry's report.

9. Findings of fact were made on the basis of the evidence received by the Inquiry.
10. Comments, which appear within the narrative of the report and any recommendations, were based on those findings of fact.

We met with Paul Horrocks at the Scott Clinic. Although we invited members of his family to participate in the Inquiry, they declined to do so.

We received a great deal of documentary evidence, which included medical records and police statements. These were invaluable in piecing together the events in late 1998. We also received policies and procedures from the various agencies involved in the care of Paul Horrocks, a list of which can be found in appendix 1.

Timescale of the Inquiry

The Inquiry met over a period of time from February 2000 until September 2000. In addition to the initial documentary evidence and following the interviews, as late as August the Inquiry received further written evidence which we also took into consideration to complete our report.

ACKNOWLEDGEMENTS

The Inquiry Team would like to acknowledge the effect that this incident had on everyone involved. We were grateful to all the people who came and gave their evidence, despite the personal distress this may have caused.

In all we interviewed 39 people. A full list of them can be found in appendix 2.

We were indebted for the help and administrative support of Mrs Sylvia Reynolds who ensured that we had all the documentation we required.

The work of the Inquiry was made all the easier by the thoughtful and comprehensive indexing of Paul Horrocks' case notes by Ms Suzannne Robinson.

We were also greatly helped by the efficient manner that Fiona Shipley Transcription Service promptly provided us with the transcriptions of all our interviews.

We met with members of the Houghton family, accompanied by Mr Paul Etherington, Chief Officer of Wirral Community Health Council. At this meeting the family posed a series of questions to us and we hope that our report goes some way to answering them.

Background

At the beginning of our Inquiry we were told that a disciplinary hearing had been conducted as a consequence of the Trust's Internal Inquiry. Prior to us commencing our work, two members of staff had been suspended. We were given to understand that one person had been re-instated and the second member of staff retired from the service.

During an interview with a Community Psychiatric Nurse (CPN) it became clear to us that there were wider issues in relation to their service. The Inquiry Team therefore took the decision to meet with a group of CPNs to hear at first hand from them what these issues were. This group was self-selected and in all was made up of 17 people. The majority of CPNs working in the Community Mental Health Teams on the Wirral were present.

The Inquiry was also asked to meet representatives of the Royal College of Nursing and Unison and we agreed to do so. During this meeting the Inquiry learned that there was an outstanding grievance between the CPNs working on the Wirral and the Trust. This had been ongoing since the early part of 1999 and we were pleased to learn that it was eventually brought to a successful conclusion during the latter part of our Inquiry.

CHAPTER 1 PAUL HORROCKS' EARLY YEARS

Paul Horrocks was born on 15 July 1970 and was brought up in the Neston area. He had a brother who was two years younger. His father died of cancer aged 29 following a lengthy illness, when Paul was only four and a half years old. It was reported that Paul had been close to him. His father was described as kind hearted and a good father.

1975

Paul went to an ordinary primary school where he coped quite well until the age of nine years old when he was transferred to a residential school because it was felt he was *"a bit slow"* and because he was behaving aggressively to his siblings.

1979

By 1979 his mother was cohabiting with a man who was reported to have been unemployed and to have had a drink problem. They later married and went on to have four children, Paul Horrocks' half sisters. Later his mother was said to have had depressive breakdowns, and to have attempted suicide by taking more than one overdose and on one occasion by slashing her wrists. Paul did not get on with his stepfather. There were suspicions that Paul and his brother had been subject to non-accidental injury (NAI). It was thought that their stepfather and their mother might have caused the injuries.

Paul was referred to the Child and Adolescent Psychiatric Services as his mother was finding him more difficult to manage. There were reports of friction and fighting between his mother and stepfather, and of his mother becoming more aggressive and rejecting towards Paul. She complained that he was stubborn and difficult to manage.

He was admitted to the Pensby Children's Wing on 23 May 1979, and discharged in October 1979. On admission, Paul was described as sallow, very small and thin, an anxious child who was embarrassed by his incontinence. He disliked his primary school and he complained of being frequently smacked by teachers and of being bullied by the other boys. Paul spoke well of his mother but resented his stepfather. Paul had been constantly fighting with his brother and showed marked aggression with other children. During his hospital stay, Paul complained of being hit frequently by his stepfather and of being constantly teased by him because of his bedwetting.

Comment

This information only appears in the general practitioner records. If it had been made available to the psychiatric services earlier, it would have helped to provide a fuller assessment of Paul's psychological development and personality problems.

Paul was described as "stunted both physically and emotionally" and it was agreed that he needed to go to a residential school. He was received into care, and attended Taupin Hough Residential School. Following this his soiling stopped and bedwetting became less frequent. He stayed in this school for two years.

Comment

His mother remarried in 1980. From the evidence we have seen Paul did not appear to get on with his stepfather at any time, despite the suggestion that his relationship with him improved for a while. The apparent improvement could have been due to Paul's increased self-esteem and his improved ability to cope with his home situation.

1982

In June 1982 he was seen as an outpatient at Arrowe Park Hospital because of a deep burn to his right lower leg. The medical recommendation was for Paul to stay on the Wirral for follow up treatment, but his stepfather insisted that he went back to school. Arrangements were made for Paul's care to be transferred to Leighton Hospital, where he later had skin grafting to his leg. Fortunately he recovered from this injury without significant scarring.

Comment

This injury was said to have been caused by petrol being thrown over his leg. This was a serious unexplained injury. We had no evidence that there was an investigation, or indeed any further action by any professional. The lack of an investigation at a period when there was an acute awareness of the extent of NAI is very concerning. Lack of action at this stage may have had a crucial impact on Mr Horrocks' subsequent history.

At the age of 12 years Paul was transferred to Cloughwood Residential School where he remained until he was 15 years old.

1985

On leaving school Paul did not return home but went to live with his paternal grandmother in Shropshire. He obtained an apprenticeship as a welder, but told us that he could not secure a permanent position because he came from Birkenhead. He felt that people were prejudiced against him because of his accent.

1988

In March 1988 Paul was made subject to a probation order of 18 months and ordered to pay £25 compensation after being convicted of causing criminal damage. Later in the same year, when Paul was 18 years old, he came to the attention of the Courts again. Paul and three others, two young men and a girl, faced charges related to an aggravated burglary.

During this incident Paul threatened an old lady, who was over 80 years old, forcing her to hand over her rings from her fingers whilst he prodded her with her walking stick. She later died, after Paul had been convicted but before sentencing. He was given three custodial sentences of six years, 18 months and three months to run concurrently.

Comment

The other two young men received custodial sentences of two years and six months respectively, whilst the young woman received a referred caution. Paul Horrocks' sentence appears unusually harsh. We can only assume that the Court took into consideration the violent nature of the attack on the old lady and her subsequent death.

Paul's first three years in custody were spent in HMP Castington, which he described as "rough". To complete his sentence he was moved to HMP Risley.

1992

When Paul was released from prison he went to live with his family in Neston. At first all was well, but he then began to speak about tagging and tiny computers which could be used to magnetise pins and ball bearings. He was extremely quiet and would not go out of doors. He accused his mother of having conversations about him with 'Mary' or 'Margaret'. He claimed that there were people hiding behind the couch and that his mother was conspiring against him.

Comment

Following the later attack on his mother and stepfather, Paul Horrocks revealed symptoms which he had experienced at this time, but which he had not previously mentioned. "He didn't want to know anybody". He had become increasingly depressed and had started to experience visual misperceptions, pictures of people jumping about on the walls. He had become paranoid about people and felt anxious in company. He thought people were threatening him and trying to intimidate him into violence.

1993

Paul refused to seek medical advice or even to register with a general practitioner. By January 1993 the acute disturbance seemed to have settled, and he started to go out of the house, ostensibly to enroll at a local Art College. In fact he didn't attend the college, and probably spent much of his time in a local public house. He spent his grant on alcohol and frequently went home inebriated, although this stopped in July, possibly because this money ran out.

In December 1993 Paul began to feel frightened again, refusing to go out of the house unless accompanied by his brother.

1994

On 16 March 1994 matters came to a head in an explosion of violence. Paul and his stepfather had a row which led to a fight, in which his mother had her nose broken and he attacked his stepfather. When the police were called, Paul stabbed a police officer in the leg with a fork. Paul had been drinking and admitted to having consumed four pints of lager. Paul considered himself to have been "tipsy" but not drunk. He was arrested and charged with actual bodily harm, wounding and criminal damage. He was remanded to prison.

According to Paul, he had been trying to warn his stepfather against associating with prostitutes in London who were capable of tracking him back home by placing magnetised pins in his clothes. Paul was convinced his stepfather was under the influence of a neighbour and of prostitutes. He believed he had seen a tagging machine in the neighbour's house. The tagging machine was used to make his clothes invisible. Paul believed that because of this, on one occasion he had been left in his boxer shorts in the street. Paul said that at times he heard voices whilst in company, but never when he was on his own.

His mother gave a different account. According to her, Paul had arrived home drunk, and had an argument with his brother. He tipped his sister's jelly onto the floor. His mother hit him with a tea towel; he retaliated and broke her nose. His stepfather was in the bathroom, and Paul went upstairs where he started hitting him and shouting "tell my mum about the prostitutes". The police were called. Paul locked himself in the dining room and smashed the windows. The police intervened, and in the course of a struggle a police officer was stabbed in the leg with a fork.

Whilst on remand Paul was interviewed by a probation officer for a pre-sentence report. He presented as withdrawn and displayed a lack of emotion. He had a delusional belief that he was a famous comedian called Paul Monroe. The probation officer and Paul's solicitor agreed that it would be appropriate to seek a psychiatric report. The probation officer wrote:

" Mr. Horrocks is a risk to the public, especially his stepfather whom at interview he said he would again attack. I must inform the Court that I cannot be certain as to whether Mr. Horrocks' behaviour is a reflection of excessive alcohol and or the use of drugs or simply one of attitude. Given his behaviour Mr. Horrocks could well be schizophrenic".

On the 4 May 1994, Paul Horrocks was seen by Dr James Higgins, Forensic Consultant Psychiatrist. Paul was reluctant to give any information about his feelings and was "expressionless". However he spoke enthusiastically about the tagging machines and the activities of the prostitutes. Dr Higgins summarised what Paul had told him:

"these are tiny computers with abbreviated digits on them which enable persons to magnetise a pin or ball bearing. They are used by the police, prison officers, the army and prostitutes. Such individuals 'stitch you up' by putting pins or ball bearings in your clothing. They follow you as your address is on the screen and they come to your home and rob you".

Paul went on to tell Dr Higgins that he was so concerned by what was happening to him that he was afraid to take his money out of the bank. He could tell that he was being 'stitched up'. Firstly, he could hear a male or female voice, which told him to behave in particular ways. Secondly, he felt as if he was hypnotised. On waking this made him behave in a peculiar manner, for example, stripping off his clothes in the street in Chester and in the local railway station.

Dr Higgins concluded that Paul Horrocks was suffering from a mental illness and that it was highly likely that the symptoms of this illness played a significant part in the offences. He said that Paul presented with a peculiar picture, showing no behavioural disturbance and no evidence of reacting to hallucinations. He was of average intellectual ability and was not obviously cognitively impaired. He had no insight into his mental illness and he did not wish to have any treatment. Dr Higgins recommended a hospital order for compulsory treatment under Section 37 of the Mental Health Act 1983.

Dr Caroline Sullivan, Consultant Psychiatrist, also saw Paul Horrocks and agreed with Dr Higgins' assessment. Arrangements were made to transfer Paul from HMP Walton to Clatterbridge Hospital under Section 37 of the Mental Health Act 1983. Dr Sullivan wrote:

"He does not believe that he is ill nor that he needs treatment. In the past he has acted upon his delusional ideas and could pose a danger to others. Treatment could only be given on a compulsory basis and in hospital".

On 9 May 1994, at Knutsford Crown Court, Paul Horrocks was convicted of four offences: two counts of Unlawful Wounding, one of Actual Bodily Harm and one of Damage to Property. It was ordered that within 28 days he should be transferred to Clatterbridge Hospital.

CHAPTER 2: ADMISSION TO CLATTERBRIDGE HOSPITAL

On 5 July 1994 Paul Horrocks was admitted to Clatterbridge Hospital. On admission he was unkempt, slightly suspicious and complained of feeling *"a bit down"*. He did not believe that he was mentally ill.

The nursing notes stated that he settled well and accepted medication, trifluoperazine and procyclidine. He was still expressing delusions about his stepfather and prostitutes who he said were working in Neston.

Over the next few months Paul settled reasonably well on the ward, but on occasions became withdrawn and isolated, complaining of feelings of depression. He did not participate in the ward activities, but did enjoy pottery classes at one time.

He continued to be concerned about his mother, worrying that she was *"piggy in the middle"*. He was not sure whether he wanted to remain in touch with his family. At times Paul still experienced auditory hallucinations, such as noises like laughing and music. He described visual hallucinations like daydreams. At times he became depressed, but this decreased as the months went by. He did not always take care of his personal hygiene.

As the year wore on, Paul became less bothered by psychotic symptoms, although they were always present. He continued to believe that a neighbour was using a machine to cause hallucinations, despite increased doses of trifluoperazine and a later change to pimozide.

Paul was taken on visits to Neston by staff, and on one occasion met an aunt in the supermarket. This prompted his mother to telephone the ward in order to complain, as she had thought that Paul would never be allowed in Neston again. Paul had also telephoned his mother, and this had made her angry. On one occasion he had telephoned home and his stepfather answered. His stepfather was angry and abusive, and threatened Paul with the police. Paul still believed his stepfather was involved with prostitutes and that if he went back home, he would be tagged. Paul accepted that he would have to live in a hostel and he was already attending a day centre and a drop in centre.

In December 1994, Paul Horrocks was referred to the Social Network Therapy service with a view to improving his community contacts. He was seen by Mr Simon Bridges. The purpose for the referral was to improve Paul's social skills, to provide support in finding a social life out of the hospital, and to ensure that he was able to keep appointments with his general practitioner and the hospital. Mr Bridges took Paul out of the hospital to social events. He continued to visit Paul in hospital every two weeks, with the intention of building up a trusting relationship, ready for his discharge from hospital.

On 14 December 1994 the Clatterbridge Hospital Mental Health Act Managers held a hearing at which it was agreed to renew Paul's detention under Section 37 of the Mental Health Act 1983. Prior to the hearing both Dr Sullivan and Ms Karen Jones, Approved Social Worker, had prepared reports recommending that detention should be continued.

A Section 117 (pre-discharge) meeting was held on 13 December 1994. Present were Dr Sullivan, Karen Jones, Mr Bridges, Ms Carol Bowden from Roscoe Day Service, Ms Pamela Taylor, a ward nurse and Ms Linda Wilkinson, Community Psychiatric Nurse (CPN). A decision was taken at the meeting to look for appropriate accommodation, and for Paul to continue with day care away from the ward.

1995

By January 1995, although Dr Sullivan had changed Paul's medication, there had been little change in his mental state. She was concerned about the danger Paul might pose in the community to his mother, his stepfather and their neighbour. She felt that Paul harboured great resentment towards his family, because he felt he was pushed out of his home. The only time he was animated was when he talked about the assault and violent fantasies that he had experienced in the past. He described these as Bugs Bunny cartoons that he replayed in his head, and in which the characters came to a violent end.

Because of these concerns, Dr Sullivan requested that Dr Higgins should review Paul Horrocks, as plans were in hand for Paul to be transferred from hospital to a suitable hostel, away from the Neston area. Dr Higgins assessed Paul. Dr Higgins felt that Paul could safely be discharged, providing certain conditions were met, including that he should live away from the Neston area. He suggested that Birkenhead was far enough away, and that this would enable Paul to continue with some of the links that he had already made, by attending the day centre, Roscoe Court. In his assessment, Dr Higgins felt that, at some time in the future, Paul might need to take clozapine. If he stopped taking medication, then a depot preparation would need to be considered.

Dr Higgins finished his assessment by saying:

" What is most disheartening about this case is not the element of risk but how apathetic and lacking in drive he is considering he is only 24 years old. Motivating him and preventing social deterioration is, I think, going to be a bigger task in his case than managing risk".

Comment

It is noteworthy that, despite all the concerns leading to the request for an assessment by Dr Higgins, there was no record of any attempt to obtain a full psychological needs assessment. Had this taken place, it might have helped the clinicians to have a better understanding of any deficiencies and vulnerabilities in his psychological profile. The absence of psychology input may have had an important impact on the decision-making processes.

CHAPTER 3 THE MOVE TO KNOWSLEY ROAD

In February 1995, Ms Karen Jones, Paul's social worker, took him to Knowsley Road Residential Care Home, with a view to him spending occasional days and a night there. By the end of March 1995, Paul was residing permanently at Knowsley Road on extended Section 17 leave. He was finally discharged from the ward on 30 March 1995. He was still taking prescribed medication, risperidone and procyclidine. Paul was discharged from detention under Section 37 of the Mental Health Act 1983, and a decision was made not to include his name on the Supervision Register. He was subject to the Care Programme Approach (CPA) level 2, and Section 117 aftercare meetings. Ms Jones became the nominated key worker.

Between March and July, Paul Horrocks was reported as still having ideas about tagging. He complained of boredom with his current activities and he wanted to move to his own flat.

In July 1995 Dr Sullivan left the adult mental health service and moved to old age psychiatry. Dr Rafeek Mahmood, Consultant Psychiatrist and Medical Director of Wirral Hospital NHS Trust, became responsible for Paul Horrocks' care.

A junior doctor saw Paul Horrocks in outpatients in October 1995. He was still taking his medication, he was seeing Mr Bridges, Ms Jones and Ms Linda Wilkinson, Community Psychiatric Nurse (CPN). He admitted to drinking 10 units of alcohol per week and denied taking illicit drugs. The junior doctor found no evidence of psychosis. Paul denied experiencing hallucinations. An arrangement was made for him to be seen in the outpatient clinic in three months.

By December, Paul was becoming more fed up with being at Knowsley Road and wanted to move on.

1996

In February 1996, Ms Jones wrote to Dr Mahmood because she was concerned about Paul's mental state. She requested a Section 117 meeting. According to Mr Henk De Rooy, the owner of the Knowsley Road hostel, Paul had started to discuss tagging and prostitutes again.

In April 1996, Ms Jones updated the care plan, which was still to pursue a Section 117 meeting with Dr Mahmood, continue with the placement at Knowsley Road and to explore the possibility of supported housing.

In July 1996, the responsibility for Paul Horrocks' care transferred from Dr Mahmood to Dr M Al-Bachari, Consultant Psychiatrist. This also meant the end of Ms Wilkinson's involvement, as she did not work with Dr Al-Bachari's team.

Comment

Dr Mahmood never met Paul Horrocks in the year that he was Paul Horrocks' RMO. Junior doctors saw Paul Horrocks on each occasion despite the fact that he had been previously detained under Section 37 of the Mental Health Act 1983. There was no Section 117 meeting, despite requests from the key worker.

Following the transfer of care, Paul was seen in the outpatient clinic by Dr Al-Bachari's Senior House Officer (SHO), Dr Sarah Palmer. She described him as 'euthymic'. Paul Horrocks wanted to stop taking risperidone, but this medication was continued because of his previous violent history. Dr Palmer recognised that she could not be sure that he was compliant with medication. A further appointment was arranged for three months time.

Ms Jones wrote to Dr Al-Bachari requesting a Section 117 meeting and this was duly arranged for 29 October 1996.

In August 1996 Paul threatened to assault another resident after an altercation, and he searched the home for a knife to 'stick' the other man. A serious assault was only averted by the timely intervention by a member of staff.

Ms Jones passed on this information to Dr Al-Bachari, as well as her concerns about Paul's medication. Mr De Rooy wrote to Ms Jones as key worker because he was concerned about the incident. He also felt there was a problem with contradictory messages being given to Paul from the various professionals involved in his care.

Comment

When we met with Paul Horrocks we discussed this incident. He told us in a 'chilling' manner that he thought it was quite acceptable behaviour to threaten to stab the other resident with a knife. He had entered Paul Horrocks' room without permission.

On 20 August 1996, Dr Palmer reviewed Paul Horrocks in outpatients at the request of Mr De Rooy. On examination, she felt that Paul was not psychotic and that he had reasonable insight into his difficulties. He expressed frustration at living at Knowsley Road. He resented the regimented daily routine and the small amount of money available to him. Dr Palmer went on to say:

"It seems a shame that such a young man should feel such frustration and it is therefore I am sure only a matter of time before he starts displaying his frustrations in a violent way".

The Section 117 meeting was brought forward from October and held on 29 August. Dr Al–Bachari was on annual leave, and a locum Consultant, Dr Hadi, discussed Paul Horrocks with Dr Palmer as well as interviewing him prior to the meeting. The meeting was attended by Paul Horrocks, Ms Jones, Dr Palmer, Dr Hadi, and Mr and Mrs De Rooy from Knowsley Road. It was a difficult meeting. Issues discussed were Paul's potential for violence, his alcohol consumption and his future residential needs. Mr De Rooy stated that as far as the hostel was concerned, Paul was relying heavily on alcohol. Paul was taking medication but Mr De Rooy questioned whether it was the correct medication as, in his opinion, Paul continued to be psychotic. He thought Paul should have a psychological assessment. He complained that the professionals were un-communicative. There were concerns about Paul's increased reliance on alcohol to enable him to socialise. The outcome of the meeting was that Karen Jones would explore more independent accommodation and that Paul should stay at Knowsley Road in the meantime.

Comment

This was the first Section 117 meeting since 30 May 1995, despite requests to the Consultants and a national requirement to hold one at least every six months.

During September and October 1996 an application was made on Paul Horrocks' behalf to find alternative supported housing for him. In the supporting letter from Dr Palmer to a Housing Association she stated:

"Although he had some problems in 1994 he had now received excellent rehabilitation at Knowsley Road but I feel now a positive step should be made for him to live independently in the community. He is not psychotic and has remained compliant with his medication and out patient appointments at all stages".

Simon Bridges, who was also asked for his views, said:

"Under the care regime established in the hospital including medication, he has settled very well and at no time in my dealings with him has he been anything other than courteous and appropriate in speech and behaviour".

Comment

These letters did not accurately reflect the situation as it was. Information given to housing providers must present a realistic assessment of the tenant's difficulties and vulnerabilities.

On 19 November 1996, Paul failed to attend an outpatient appointment. It had been agreed that this appointment would be regarded as a Section 117 meeting. A computerised letter informing the general practitioner (GP) of this non-attendance was automatically sent in the name of Dr Al-Bachari.

In December 1996 the Trust Mental Health Act administrator sent a letter about Paul Horrocks to Ms Wilkinson, CPN, requesting information about his status under the Mental Health Act 1983. He was still subject to aftercare and a review should have taken place every six months.

Comment

The Trust had introduced a mechanism to prompt Section 117 reviews. However, no meeting was arranged at this time. Ms Wilkinson had ceased to be involved with Paul earlier, and there did not appear to be another allocated CPN.

1997

On 27 March 1997, a CPA/Section 117 meeting was held at the hospital, but Paul failed to attend. The people present were Ms Jones, Social Worker, Mr Bridges, Social Network Therapist and Dr Costigan, SHO to Dr Elhibir (who was now the Consultant responsible for Paul Horrocks).

Comment

We were unable to find any kind of written handover or plan for his continued care. Dr Elhibir was the fourth doctor with responsibility for Paul Horrocks since Dr Sullivan had left. He told the Internal Inquiry he had not had the time to read the case notes when he took over his care. (Appendix 14, minutes of meeting 5 February 1999).

Dr Elhibir was an associate specialist working as a locum Consultant. He is not qualified to hold a substantive Consultant psychiatrist post in the United Kingdom, as he does not hold Membership of the Royal College of Psychiatrists (or an equivalent qualification), the main specialist qualification in psychiatry in this country.

At the meeting it was reported that Paul was well and that he was keen to move into independent accommodation. Before this could happen another CPA meeting would be held at Knowsley Road. The plan was to continue as before, with visits from the social worker and Mr Bridges, and for him to be seen in clinic again in three months.

At this time Ms Jones carried out a risk assessment based on the document 'the role of the social worker' by Michael Sheppard, in which she stated:

"Stepfather has threatened to attack Paul if he ever returns to Neston", and later in the document "no one requires protection from Paul whilst he continues to take medication. Becomes delusional and aggressive if he stops taking".

Comment

There is no doubt as to the experience, dedication and perceptions of Ms Jones. She told us that she prepared this document in the absence of any locally agreed risk assessment instrument and although she forwarded her risk assessment to the CMHT there was no evidence that anyone took any further action.

On 30 April 1997, Paul attended the outpatient clinic to see Dr Costigan, Dr Elhibir's SHO, on his own. There were no psychotic features detected and he denied any feelings of aggression. He reported he was taking his medication and admitted to drinking five pints two or three times in a week. He stated he had a girlfriend. He intended to go back to college and then look for work. He was to be seen in the outpatient clinic in three months.

In May 1997, Ms Jones wrote to Paul, as the placement at Knowsley Road was not permanent and she wished to discuss his future housing needs.

CHAPTER 4 THE MOVE FROM KNOWSLEY ROAD TO INDEPENDENT ACCOMMODATION

On the 9 June 1997, Paul Horrocks gave one month's notice to leave Knowsley Road, as he was moving into a house in Menai Street at the end of that month. Mr Bridges saw him in his new house. His mental state was reportedly good and he was making social contacts on his own. Mr Bridges stated in his notes:

" I will stay involved at the moment on a weekly basis but once Paul is fully established on his own I will consider discharge".

On 30 July 1997, Paul failed to keep his outpatient appointment, and a standard computer generated letter was sent to his general practitioner (GP).

On 7 August 1997 Mr Bridges visited Paul at home and found him anxious about his previous girlfriend, who he said was claiming that he was the father of her unborn child. He agreed to visit Paul again in one week.

On 28 August 1997, Dr Mawdsley, his GP, referred Paul Horrocks to Mr Con Quick CPN. The referral stated *"now in the community arrange CPN to visit".*

Comment

Mr Quick told us that when Paul Horrocks was referred to him, he was not aware of any of his previous psychiatric history or care package. It was "just another referral by the GP". We were surprised when Mr Quick told us that all the information he had was that Paul Horrocks had recently been in residential care and that he was now living independently. He was asked to provide additional support. He told us the only information he had was a couple of lines from the GP via the receptionist. Mr Quick did not familiarise himself with the notes and therefore did not know Paul Horrocks' previous history; that there was a key worker and somebody from Social Network Therapy was involved. When we discussed this with Ms Jones she seemed a little taken aback and said, *"he could hardly not have known".*

On 3 September 1997, Mr Bridges visited Paul and found him depressed. It emerged that he had taken an overdose of his prescribed medication and paracetamol the previous week. Earlier that day Paul had gone to Knowlsey Road and had behaved in a bizarre, irrational manner. Mr Bridges took Paul to see Dr Mawdsley, his GP, who prescribed dothiepin, an antidepressant and made a note:

" Not actively suicidal now some ideas re tagging machine but can't elucidate".

Comment

In retrospect Paul Horrocks' comments about 'tagging' could have been identified as a warning sign of future risk. The weakness in the system was such that this information was not taken seriously.

On 9 September 1997, a neighbour called the Ambulance Service because Paul was feeling depressed. The ambulance log stated:

" Patient willing to and eager to talk to a psychiatrist with the possibility of being admitted to Clatt. Has been prescribed med. But has not been taking it, saying he prefers to have a beer which has a calming effect. Registered schizophrenic".

When Paul Horrocks saw the duty psychiatrist, he told him that he had not collected his prescription from the chemist. The duty doctor did not admit him but advised him to go to his GP in order to obtain a further prescription.

Comment

The failure of the duty doctor to either inform Dr Elhibir or to intervene himself illustrates the fragmented nature of the care offered by the mental health services. During this critical period in Paul Horrocks' life, his GP, the community based psychiatric service and the emergency services were all operating in complete isolation from each other.

On 10 September 1997, Mr Bridges visited Paul again and still found him depressed. His previous girlfriend had told him that she had lost her baby, and this had made him feel worse.

Paul had seen his GP and commenced dothiepin.

On 24 September 1997, Paul failed to keep his outpatient appointment and a standard computerised letter was sent to his general practitioner.

In September 1997, Ms Jones went on maternity leave and the key worker role passed to Mr Ray Bennett, a social work colleague from the same office.

On 4 November 1997, Mr Bennett contacted the CPA office at Clatterbridge Hospital to enquire about a Section 117 meeting, and whether a date had been arranged.

On 12 November 1997, Paul attended the outpatient clinic and was seen by Dr Omotayo, SHO to Dr Elhibir. He detected no psychotic or depressive features. Paul was to be seen again in six months and Mr Quick was to offer support. Dr Omotayo wrote in a letter to the GP that Paul Horrocks' medication was to remain as risperidone and dothiepin.

On 21 November 1997, Mr Bennett made contact with Mr Bridges, and told him that Paul Horrocks was socially isolated and drinking heavily. They made arrangements to visit Paul together the following week, although, in actual fact, the visit did not take place for 11 days.

On 2 December 1997, Paul Horrocks was seen again at the hospital as he had tried to hang himself. He had been advised to go to the hospital by Mr Quick. He had been drinking heavily with friends and his sister, and he was *'paralytic'*. He had tried to hang himself on a bannister, but the rope broke. Paul was relieved that he was not successful and he attributed his behaviour to heavy drinking. There was a discussion with Dr Elhibir's junior doctor who agreed to review him in the next four weeks. The CPN was informed and planned to visit the next day.

Comment

There was no evidence in the records that Mr Quick informed the key worker of Paul Horrocks' attempted self-harm.

On 3 December 1997, as previously arranged, Mr Bennett and Mr Bridges visited Paul and learned that he had tried to hang himself the previous evening. They decided that a Section 117 meeting should be arranged as a matter of urgency.

On 18 December 1997, the Section 117 meeting was held and Paul, Mr Bridges and Mr Bennett, as well as Dr Elhibir, were present. Paul was said to be mentally stable and not showing any signs of depression. Paul wanted to return to Neston, and Dr Elhibir stated that he saw no legal reason why this could not happen. It was agreed that Mr Bennett would write to Paul's mother to seek her opinion on this matter. The issue of transferring care and key worker responsibility from the Ellesmere Port social work team to Wirral Social Services would be resolved when it was known where he would be living, in the light of the possibility of Paul returning to Neston.

Comment

If Paul Horrocks had been able to move to Neston, then he would still have remained in the catchment area for the Ellesmere Port social workers. However, if he did not move, then he was in the catchment area of the Wirral Social Services and the case needed to be transferred.

1998

On 13 January 1998, Paul Horrocks failed to attend for an outpatient appointment with Dr Elhibir and a standard computerised letter was sent to the GP. The letter stated *"this patient was due to attend the above department on 13/01/98 but failed to attend. There will be a further appointment made and notified to the patient"*. The letter was sent out in the name of Dr Elhibir but not signed by him.

On 13 January 1998 Mr Bennett received a reply to his letter from Paul Horrocks' mother. In it she said, *"I am not able to help Paul's situation. My nerves are shattered to think that Paul wants to return to Neston. I am petrified of meeting him. I do not want Paul to move back because he is not on any medication and it would only take a pint to make him explode. It would be like waiting for a time bomb to go off. My husband will never forget or forgive him for what he did to him or myself or my home. Next time I don't think my husband would survive the beating that Paul gave him as my husband never got over it. We were the only ones who stuck by Paul when he came out of prison. I do not want any contact with you any more about this. I do not want Paul to move back to Neston"*.

Comment

It is unclear whether Paul Horrocks was told of the content of this letter. We know that Mr Bennett had tried to visit him but Paul was out. Certainly when we met Paul Horrocks, he felt it was nothing to do with the professionals where he lived, nor did he appreciate the significance of their concern if he moved nearer his family.

A repeat prescription for risperidone was issued on 22 January 1998.

On 27 January 1998, Mr Bridges visited Paul. Paul had had a disagreement with another person and was feeling harassed about it. He felt insecure in his housing, as this person knew where he lived. If he was unable to move house, he was thinking of moving in with another friend.

On 10 February 1998, Paul Horrocks was admitted to Arrowe Park Hospital, having taken an overdose of dothiepin tablets. Whilst on the ward he was referred to Mr Michael Gailey, Nurse Specialist in Liaison Psychiatry.

Comment

Unfortunately the record of this interview could not be found and Mr Gailey was not able to recall any details. This was the only record of Mr Horrocks' care that we were unable to obtain. Mr Gailey did recall that he had no previous knowledge of Mr Horrocks and that he did not know that he had schizophrenia. Paul Horrocks informed Mr Gailey that Mr Quick was involved with him.

Mr Gailey told us that information was faxed to the GP and that the mental health team were notified of Mr Horrocks' admission. There was nothing in the records to verify any communication of information. As a consequence the key worker, Mr Bennett although unknown to Mr Gailey, was not aware of any of the incidents involving self-harm.

On 23 February 1998, Paul Horrocks attended his GP, complaining of nausea after eating. He smelt of alcohol and admitted to drinking six pints a week. He said that he was taking risperidone but that he was no longer taking dothiepin.

On 9 March 1998, Mr Bridges did a home visit and found that Paul was not as well as he had been. He made poor eye contact, he seemed a little suspicious and his conversation was without its usual flow. His GP had discontinued dothiepin and Paul had stopped taking risperidone of his own accord.

On 19 March 1998, a CPA meeting was held. Mr Bridges took Paul to the meeting, which was also attended by Dr Elhibir and Mr Bennett. Mr Quick, the CPN, sent his apologies. The plan was, following this meeting, to nominate Mr Quick as key worker. Mr Bennett would no longer be involved, as Ms Jones was returning to work in April 1998. Dr Elhibir wanted Paul to have blood taken for liver function tests and to have an electrocardiogram (ECG). It was planned that Paul's medication would change from risperidone when the test results were available.

Comment

The Inquiry Team found it difficult to understand why the key worker role was allocated to a person who was not present at the meeting. The purpose of an ECG prior to a change of medication in a young man was obscure to us. It is possible that a more prompt response to Paul Horrocks' request for a change of medication would have secured his co-operation in taking medication.

On 8 April 1998, Ms Jones wrote to Paul Horrocks informing him that she had returned to work and wished to visit him. She saw him on 17 April and afterwards wrote:

"Looks awful not taking medication. Wants to move. Smashed TV and depressed with angry outbursts".

In completing the Client Standard Assessment Form, in order to transfer the case to the Wirral Social Services, she wrote, *" feels lonely and isolated, to be expected after living in residential care. Needs prompting with medication, does not feel he needs it. Paul likes to spend time in pubs and drinking. Has a diagnosis of paranoid schizophrenia. Has recently smashed TV and pulled fire off the wall. Mental health needs closer monitoring as delusions re-emerge when not taking medication".*

Comment

Dr Elhibir wanted to prescribe depixol, an intramuscular medication, for Paul because he had deteriorated. Paul had become paranoid about local pubs and he believed that people thought he was being tagged. When we interviewed Mr Quick, he had no recollection of this, but he did recall the fire being off the wall and the TV smashed. When we asked him for his reaction to this, he felt it was not unusual and that it was a way in which young men dealt with their frustration. This was in sharp contrast to the reaction of Ms Jones, who saw the behaviour to be a result of his mental health deterioration, particularly as he was not eating and looked as if he was not taking care of himself. She referred to this state of affairs on her return as a *"shock".*

On 20 May 1998, a CPA meeting was held. Dr Elhibir, Ms Jones and Mr Quick were present. Mr Bridges was unable to attend but wrote a detailed letter:

"Since Paul left Knowsley Road in June of last year I have seen a gradual deterioration in his mental state. He has stopped attending SNT groups and has shown a negative attitude to my attempts to encourage him towards structured activity. I feel the main cause of his present unsatisfactory situation is non-compliance with prescribed medication. He is no longer prescribed anti-depressants and has voluntarily stopped taking risperidone. A change of medication was considered at the last CPA but he is still prescribed risperidone. On 14 May I found Paul very depressed, he has lost his appetite, sleeps too much and has no enthusiasm. His thought processes have slowed markedly and he admits to paranoid thoughts and visual hallucinations. He has showed enough insight to have recommenced risperidone a couple of days ago but is having difficulty in remembering to take it".

Dr Elhibir wrote, *"main problem is compliance she (Ms Jones) thinks he has deteriorated in the time she has been away. She says he is paranoid about the local pubs. People there think he is tagged. Plan to review medication to try him on depixol after discussing with him. Con Quick to be key worker. She will transfer him to social worker in Birkenhead South Community Team. To see in clinic".*

Comment

Ms Jones told us she knew that Paul would never have agreed to injections because he had emphatically refused them in the past. She told us she was *"pushing"* for an admission. It was difficult for us to understand why Dr Elhibir did not take more notice of her comments. It may well have been because her involvement effectively came to an end at that meeting. The Inquiry Team could not understand why little notice was taken of the views of Ms Jones and Mr Bridges, who knew Paul Horrocks far better than the other professionals involved in his care. It appears that in the absence of a fully integrated multi-disciplinary team, the views of non-medical staff were not valued.

Ms Jones wrote in the care plan, *"because of Paul's history (paranoid ideas and aggression) the possibility of re-admission cannot be ruled out. Paul has not taken medication for about a year and greatly deteriorated mentally. I have written to M Sanderson regarding social work input. I have not been able to contact Paul since the meeting 20 May".*

No follow up meeting was arranged. On 4 June 1998, Ms Jones wrote to Mr Michael Sanderson, CPN Team Leader, outlining her past involvement with Paul Horrocks. As Paul was no longer in her catchment area, she could no longer continue to be his social worker. She asked for him to be allocated to another social worker in Birkenhead. Mr Quick visited Paul Horrocks, but he was unable to persuade him to have depixol injections. This was the last time that Mr Quick saw Paul Horrocks.

Comment

The Community Mental Health Team (CMHT) was managed by both Health and Social Services. Mr Sanderson, the CPN team leader, told us that at that time the social worker team leader post was vacant and as a consequence he was managing both the CPNs and the social workers, on a day to day basis. That was why Ms Jones wrote directly to him and not to Wirral Social Services Department. However, later in the Inquiry this management arrangement was disputed by the Chief Executive. Despite whatever management arrangements were in place and although Ms Jones' letter was on the file, there was no reply to it. When the Inquiry Team discussed the letter with Mr Sanderson he had no recollection of it, even though there was a copy in the health care notes. Mr Quick did know about it and told us that, *"if a social worker was needed it would have been arranged as we were now all working in the same team".* Clearly Ms Jones attempted to alert the receiving service of the importance of allocating a new social worker to Paul Horrocks, hence the letter emphasising this to Mr Sanderson. Unfortunately, whatever happened to the letter, given Mr Quick's decision not to refer, Paul Horrocks was lost to social work follow up.

On 8 June 1998, Ms Jones wrote to Paul explaining that she was no longer the key worker and that Mr Quick would now take this responsibility.

After making three unsuccessful visits at weekly intervals, on 22 June 1998 Mr Bridges visited and found Paul Horrocks at home. After a previous visit on 11 June 1998, when Paul Horrocks was out, Mr Bridges had made the decision to discharge him should there be further failed visits. Paul told Mr Bridges that he wanted to move house as soon as possible. He was not sleeping well. He said that he was taking his medication intermittently. Paul said he was involved with a woman.

On 10 July 1998, Mr Bridges visited Paul and found him at home. Paul wanted to borrow some money as he had many outstanding bills. Mr Bridges declined to lend him any money. Paul said he had a girlfriend called Carol. Mr Bridges thought the relationship would be good for Paul. Mr Bridges wrote in his notes:

"no further interventions identified but I feel Paul very much needs support at present so will keep on caseload".

On 16 July 1998, the CPN had a failed visit.

On 24 July 1998, Mr Bridges visited Paul at home. Paul told him that his social life now revolved around Carol and her family.

On 28 July 1998, Paul Horrocks failed to attend an outpatient appointment and a standard letter was sent to his GP. The letter stated, *"this patient was due to attend the above department on 28/07/98 but failed to attend. There will be a further appointment made and notified to the patient"*. On this occasion there was no signature.

On 31 July 1998, Mr Bridges visited Paul Horrocks. As Paul had no medication, they went to the GP for a prescription. However, they could not collect it, as all the chemists were closed.

Comment

The last entry in the general practitioner prescription records, dated 10 July 1998, was for risperidone. In 1997 prescriptions had been issued on a monthly basis, and the assumption was that Paul Horrocks was taking medication. In 1998 there were only three entries, in January, February and July. Therefore a reasonable assumption could be made that he was not taking medication on a regular basis for some months and not at all in late 1998.

Paul told Mr Bridges that Carol might be moving in with him. On 20 August 1998, the CPN had a failed home visit. Later that month, a neighbour saw Carol with a black eye.

On 7 September 1998, Mr Bridges visited Paul Horrocks at home. The relationship with Carol was described as 'stormy'. Paul told Mr Bridges that his benefit book had been stolen, and he had to 'sign on' weekly, which was stressful for him.

Comment

When we saw Paul Horrocks, he told us the benefit book was never stolen. Carol had his benefit book because he had borrowed money from her and she was keeping it as surety.

On 19 September 1998, the CPN had a failed home visit.

On 1 October 1998, Mr Bridges had a failed home visit.

On 6 October 1998, Paul Horrocks failed to attend an outpatient appointment. It would appear that Paul Horrocks was discharged from the outpatient clinic and a standard letter was sent to his GP, informing her of this. The letter stated, *"this patient was due to attend the above department on the 6/10/98 but failed to attend. Routinely no further appointment will be made. However if you feel one is necessary please do not hesitate to contact us"*. The letter went out in the name of Dr Elhibir but was **not** signed by him. We were unable to find any evidence or documentation, which demonstrated that any professional, took responsibility for arranging a further appointment.

Comment

The Internal Inquiry correctly identified the computerised outpatient appointment system, described to us as "three strikes and you are out 3DNAs and you're off" as being inappropriate for use in psychiatry. One of their recommendations was to ensure that clinicians now had sight of the clinic list so that they could take action. We were pleased to hear from Dr Elhibir that there was now a system in place to prevent a similar sequence of events without alerting the psychiatrist. We were surprised that the previous system for psychiatric appointments had been left in place for some years without question.

On 7 October 1998, the CPN had a failed home visit. In the evening, two police officers attended Paul Horrocks' home in response to a 999 call. The call had been made by Carol Houghton, but when the police officers arrived she had already left and gone to her mother's house. There were no lights on in Paul's house. When they entered, they saw that Paul Horrocks had blood running down his face from a cut on his forehead, and that there was blood on his hands. There were large quantities of blood on the floor, and traces in the kitchen, in the bedrooms and on the walls going upstairs. The police officers felt that the large quantity of blood around the house could not be accounted for by bleeding from Paul Horrocks' head wound. The police officers, suspecting that a serious crime had occurred, handcuffed Paul Horrocks. When a call was received to say that Carol Houghton was alive and on her way to the hospital, he was released. She was unwilling to make a complaint, and the officers left.

Carol Houghton had been drinking. She was persuaded by her mother and sister to attend the accident and emergency department, where she was found to have quite severe injuries, including a fractured jaw, a laceration to her forehead and a suspected perforated ear drum. She was kept in hospital overnight. The following day, when questioned, she said that she had sustained the injuries in a fall.

Comment

At that time, the police officers were unable to take any action against Paul Horrocks because Carol Houghton was not prepared to give evidence against him. However, in the course of the Inquiry, the Inquiry Team was told that police policy with regard to domestic violence had changed. The police now endeavour to press charges in all cases, even when the person injured is reluctant to give evidence.

On 17 October 1998, Carol Houghton again attended the accident and emergency department. She was kept in the short stay ward overnight for observation.

On 26 October 1998, Mr Bridges had a failed visit. He left a note stating he would discharge Paul if there was no further contact. Paul later telephoned Mr Bridges, and he was given another appointment.

On 2 November 1998, the CPN had a failed home visit. A neighbour called the police to the house on the same day, because Paul Horrocks had broken his bedroom window.

On 5 November 1998, Mr Bridges visited Paul, who told him that he was not taking any medication and that he was not seeing anyone else from *'psychiatry'*. Paul had also tried to visit his family in Neston, and had been rebuffed.

Paul was seen again by Mr Bridges on 26 November 1998, when his mood was rather flat. He was still not taking medication, and he had not seen the CPN. His relationship with Carol was, according to Paul, still 'stormy'. Mr Bridges agreed to maintain support until Christmas.

On 4 December 1998, Carol Houghton attended the accident and emergency department, noticeably intoxicated, and with a large haematoma on the back of her head. She could not, or would not, say how this injury had occurred.

On 16 December 1998, Mr. Bridges visited Paul at home, and found him to be unwell. He recorded that Paul's concepts of reality were a bit hazy and that it was difficult to have a conversation with him. Paul was still not taking his medication, but Mr Bridges did not feel that he was a risk to himself or to others. He made arrangements to call again between Christmas and the New Year.

Comment

It appears that Mr Bridges did not share his assessment of Paul with anyone. By assessing risk, albeit superficially, he effectively changed his role from that of 'befriender' to 'key worker'. He remained isolated from any other professional and his risk assessment could not, therefore, be thorough.

In the early hours of 27 December 1998, Paul Horrocks dialled 999 and told the Ambulance Service that he had been arguing with his girlfriend and that she was unconscious. It was recorded that he said, *"she's got a hole at the top of her nose. I kicked her in the face".*

When the ambulance and police officers arrived she was dead. Paul Horrocks told them, "she thought she was my girlfriend but she was just a prostitute". It appears that, prior to telephoning the Ambulance Service, Paul Horrocks had washed Carol and had changed her blood stained clothes for clean ones.

Comment

One of the police officers that attended on this occasion had also been present on 7 October 1998, when Carol Houghton had previously been injured.

When Mr Bridges visited as planned on 29 December 1998, he was met by a police officer. The officer informed him that Paul Horrocks had been charged with the murder of Carol Houghton on the 27 December 1998.

CHAPTER 5 PRESSURES ON THE MENTAL HEALTH SERVICE ON THE WIRRAL

In the course of our interviews, it became apparent that the mental health services on the Wirral, and especially in Birkenhead, had been operating under extraordinary pressures. As we attempted to investigate those pressures we were told of a long and unhappy history behind the problems which existed in December 1998. Those problems, in the main, still exist today in Birkenhead. We felt that it was important to piece together the sequence of events that led to these problems developing, so that the actions of individuals are seen in a proper context.

Two years on from the tragedy the Trust has corrected many of the deficiencies which contributed to the death of Carol Houghton. In order for the reader to understand how the tragedy occurred it is necessary for us to highlight the full context at the time. The following were, in our opinion, the major influences on the emerging problems in the adult mental health service in Birkenhead and indeed recognised by the Trust which had remedied some of these problems by the time of our Inquiry. We identified the following issues which were of concern at the time of Carol Houghton's death:

1. The Trust's capacity during the critical time to understand and manage the changing agenda for adult mental health
2. Recruitment and retention of staff, especially Consultant Psychiatrists
3. Staffing, restructuring and regrading of the CPN service
4. Information technology and case note management systems
5. Excessive CPN and Consultant caseloads
6. Lack of multidisciplinary working
7. An apparently inverse relationship between sector psychiatric morbidity and resources.

Our understanding of these problems has informed the recommendations we have made about the future management of the Trust.

CHAPTER 6 MANAGEMENT OF MENTAL HEALTH SERVICES AND ITS ASSOCIATED PROBLEMS

There can be real difficulties in gaining an understanding of the history of the management of any organisation. Typically, in this case there were few incontrovertible events and dates. There were many important discussions, meetings and incidents that were active in the memory of those involved, but scantily recorded. It was very difficult to bring together separate but simultaneous processes into a single chronology. Managers and clinicians have moved and changed role, so that there has rarely been a stable group working together. It was often hard to identify who had made a particular decision or when it was made.

Events have been interpreted in many different ways, and have generated completely different perceptions. In trying to understand what follows there were some contradictory accounts of events. We did not feel that anyone was attempting to mislead us. These contradictions were the inevitable consequence of different people observing the same events with different priorities and concerns, and at different places in the spectrum of power. On occasions we have preferred one account over another, almost invariably because of the balance of evidence from various sources.

Management Capacity for Change

Prior to the formation of the Wirral Trusts, the mental health service was not especially generously resourced, but had a full complement of Consultants in general adult psychiatry in post, and, from what we were told, there were no major problems with staff recruitment, retention or morale.

In 1993 responsibility for mental health services was divided between two Trusts, Wirral Hospital NHS Trust and Wirral Community Healthcare NHS Trust. The Wirral Hospital NHS Trust was a large organisation, managing the major hospital specialities on the Arrowe Park and Clatterbridge sites, and had responsibility for general adult psychiatry and old age psychiatry. The Wirral Community Healthcare NHS Trust was a much smaller organisation and had responsibility for a range of services including learning disability and child psychiatry.

In 1995, discussions took place between the Trusts and Wirral Health Authority in order to find more appropriate structures to manage all the services that included mental health.

By April 1996, Wirral Community Healthcare NHS Trust managed all mental health services on the Wirral. Until then the existing Community Trust was quite small and was thought to be non-viable in the long term. The addition of the mental health services was seen as strengthening its future position. It was unfortunate that about the same time senior psychiatrists in the adult services started to leave. Out of a complement of six Consultants and two associate specialists, four Consultants left. It proved difficult to recruit replacement Consultants and a dependence on locum doctors began.

Wirral Community Healthcare NHS Trust had taken over services which had profound problems. The Trust's management team's experience and capacity to manage general adult mental health services was limited. Mr Stephen Dalton, Chief Executive of the Community Trust, Mr Andrew Brogan and Professor Kenneth Wilson, as the newly appointed Medical Director, represented the core of psychiatric expertise at board level. Only Mr Brogan had prior experience of managing general adult psychiatric services. Such services, even when functioning well, are intrinsically complex and risk laden. They are more difficult to manage successfully than either learning disability services or child psychiatry services.

In the early days of management by Wirral Community Healthcare NHS Trust, this inexperience was evident in some clumsy decision making. Mr Brogan told us of an example of this. A patient absconded and committed suicide by jumping from a motorway bridge. Such an event demands a serious and prompt review of care and procedures. A management decision was taken which initiated detailed daily reports on all patients absconding from the wards. Absconding is a daily event in any open ward setting, and though it must be managed, it cannot be eliminated. Whilst the prevention of absconding can be very important in the protection of patients and others, not all absconding presents a danger. An excessive effort to avoid patients absconding can lead to an inappropriately custodial ward environment.

The response would appear to illustrate the lack of mental health expertise and *"nervousness"* of senior management in the Trust at that time.

In 1997, the mental health services in West Cheshire NHS Trust merged with Wirral Community Healthcare NHS Trust, which was renamed Wirral and West Cheshire Community NHS Trust. The merger was hoped to release monies to fund extra Consultant posts and service developments in mental health. It had been provoked about a year earlier by an approach from the body of Consultant Psychiatrists based in Chester, asking if they could be managed by the Trust.

From the managerial point of view, this was a very attractive development. A larger organisation has greater flexibility to use its resources to solve problems. The new Trust would be less vulnerable in the national move to rationalise and decrease the number of Trusts. A larger mental health Trust would be in a strong position to bid to manage mental health services across a greater part of Cheshire. However, the challenge of a merger seems to have distracted attention from the pressing task of resolving problems in adult mental health on the Wirral.

Recruitment and Retention of Consultants

We were told that there had been a plan to concentrate psychiatric inpatient facilities on the Clatterbridge site for some time. We also heard that, during the time Wirral Hospital NHS Trust was managing the service, the Arrowe Park mental health unit was closed. We were told that irrespective of the degree of consultation, the decision led to a situation where elderly and young patients had to temporarily share wards. There was disagreement in the evidence we heard about this. If this was the arrangement, then it was contrary to normal standards of good practice in psychiatric inpatient care.

During 1995 and 1996 five of the six Consultant general adult psychiatrists left. We were given to understand that this occurred for a variety of reasons including ill health, and retirement.

Dr Sullivan, who moved to old age psychiatry, and later left the Wirral, told us that a heavy workload and unrealistic demands were major factors in her own decision to leave. We feel that her position was particularly difficult, as she had to cover much of Dr Mahmood's clinical work in order to free him to carry out his duties as Medical Director.

Dr Mahmood gave us an explanation for the wave of Consultant resignations which was more to do with the added burdens caused by statutory and non statutory national pressures, such as the introduction of the Care Programme Approach and that Consultants were, in general, becoming more mobile. Two Consultants were recruited as replacements, but unfortunately both left within a short time. Whatever the reasons for the reduction in Consultant numbers, the outcome was to increase the pressures and difficulties in managing the adult mental health service.

Restructuring of the Community Psychiatric Nursing Service

In 1994, the Wirral Hospital NHS Trust undertook an exercise to review the grading and salary structure for the whole of the nursing workforce. Few of the Trust's nurses outside of mental health worked in the community, and consequently the criteria by which new grades were allocated did not reflect the realities of working as a CPN. Although the new structure was strictly speaking a local one, the consequences are most easily understood by reference to the national grading structure. Previously there was a mixture of G, F and E grade CPNs. This followed the common pattern across the country. Under the new structure all CPNs were E grade apart from the team leaders who were paid a little less than G grade salaries. Most of the existing CPNs were effectively downgraded. The fact that they were granted salary protection did not prevent a serious blow to team morale. No CPN seems to have received a changed job description relating to the regrading, though team leaders were given a reduced workload in order to carry out their responsibilities. Managers of the service took the decision not to 'dictate' clinical supervision arrangements which are normally mandatory for E grade CPNs. Clinical supervision, despite national and local guidance, was casual and inconsistent.

Over time the impact of the regrading was profound. As longer serving staff left, new staff on lower salaries replaced them. For reasons explained later, caseloads grew out of control. CPNs could earn more whilst carrying lower workloads in neighbouring Trusts, and those who could leave did so or took more financially advantageous positions in the Trust. Turnover of staff increased. Across the UK it is hard to recruit staff to work on psychiatric inpatient units, because CPNs are seen to have more desirable jobs. The opposite is the case on the Wirral.

Comment

We were surprised to find that the grading structure for CPNs on the Wirral remained unchanged at the time we took oral evidence, four years after the Community Trust took over the service. The Trust had inherited a much more rational grading structure in Chester, but this only exacerbated the sense of inequity.

At the time of taking verbal evidence a grievance proceeding had been in train for a year. Much later in our Inquiry we were given to understand that the finances had been identified to rectify the regrading of CPNs and that the grievance had been brought to a successful conclusion.

Computerised System for Outpatient Appointments

Wirral Hospital NHS Trust seems to have had a strong focus on computerised systems which included the ability to download laboratory results, holding clinical records on the computer and an automated system for managing outpatient clinics. When patients failed to attend, the system automatically generated an appointment for three months later, and a letter was sent to the patient's GP. After three consecutive missed appointments, the patient appeared to be discharged if the Consultant did not intervene as was the case with Dr Elhibir. Dr Sullivan told us that she had been unhappy with this system following its introduction in 1994 and arranged that her secretary held a manual appointment system. She told us she was criticised by managers for this, and she was put under pressure to use the computerised system.

Dr Elhibir told us that, at the time he was the Consultant for Paul Horrocks, he did not routinely see the notes of patients who failed to attend appointments and therefore he did not intervene in the system to rebook patients. Dr Elhibir's lack of knowledge about missed appointments was compounded by the fact that non-attendances were never the subject of the weekly meetings held between him and the CPNs.

Comment

Irrespective of whether such a system was appropriate to other specialities, it was not helpful for patients like Paul Horrocks. We agree with the Internal Inquiry's view that all non-attendances to psychiatric outpatient clinics should be assessed on clinical need and are a part of the weekly multi-disciplinary meeting.

CHAPTER 7 RESOURCE ALLOCATION AND SERVICE DEVELOPMENTS

One of the most puzzling aspects of the present Inquiry was that whilst both the Trust management and the Health Authority agreed that there have been long standing problems in the service, they had very different interpretations of the question of resources. In 1995 Wirral Health Authority and Wirral Social Services Department published a joint Strategy for Adult Mental Health Services. Some 30 months later 'The Vision - NHS Adult Mental Health Services on Wirral' was agreed by the Health Authority, Local Medical Committee and Wirral & West Cheshire Community NHS Trust. In this document, Wirral Health committed funding to the expansion of certain parts of the service. However, aside from this, commissioners of the service, both past and present, believe that they have, on more than one occasion, offered extra resources to tackle problems, and that these resources have sometimes been refused.

This seemed incredible to us, and the current Trust management were unanimous that this had never been the true situation. However, more than one middle manager confirmed that an offer of funding for extra CPNs had been refused. Furthermore, Mr Brogan told us that money had been available to develop some new aspects to the service, but that there had been a fear in the Trust Board that the Consultants would not like the new services and would leave. He told us:

"There was some central control over not wanting that money in the system... The finance director, the chief exec and the medical director cautioned against that for a) brokering the money over a period and b) there was advice given at one time about what that would mean for the Consultants – how would the Consultants manage it, and it had not been thought out enough. There was some concern that the management of the directorate level might not be able to ensure safe and supportive systems".

In recent times, through 'Vision money', there has been an increase in the resources available to employ CPNs. Sadly, retention was so poor that as fast as CPNs were recruited, others left.

Some development money was spent, but several hundred thousand pounds of desperately needed money was wasted. In 1998, an "intensive outreach" service, with attached staffed beds, was opened as a joint venture between Social Services and the Community Trust. By February 2000 the service had only taken on 7 patients and these had all been recruited very recently. By our calculation, the cumulative cost of the project to date has been around £750,000. We were variously told that the staff had had to spend most of their time so far on training or that the project was stymied by disagreements over clinical philosophy.

CPN Workload

Prior to the 1990s, the Consultants on the Wirral screened all referrals to the mental health service, and some patients were then referred on to the CPN attached to that Consultant. In 1991/92 CPNs became GP linked, but retained responsibility for those suffering from severe and enduring mental illness.

Through the mid to late 1990s, all psychiatric services struggled with contradictory centrally determined imperatives. On the one hand, the Department of Health expects services to be targeted on those, like Paul Horrocks, who suffer from severe and enduring mental illness. On the other hand, primary care tends to want mental health services to focus on those more common, but less severe, disorders which represent a high proportion of general practice workload. There has been an increasing emphasis on giving general practice the power to determine the shape of secondary services. This has included the threat of dis-investment from secondary care, with an implicit risk of the collapse of Trusts that fail to respond to general practice requirements. The CPN role has changed with little, if any, consultation between primary and secondary care. Other agencies developed waiting lists in order to cope with pressure, but the CPNs on the Wirral were not allowed to do so. The CPNs were squeezed by the conflicting pressures. *'Consequently we were like a never-ending sponge'.*

Managers of mental health services across the country have varied in the skill they have employed in balancing these demands, and in their capacity to retain their nerve in the face of demands from primary care. The Community Trust has shown little capacity to do either. They expected CPNs to provide a comprehensive service, usually as key worker, to those with serious mental illness, to hold liaison sessions in general practices and to accept direct referrals from general practitioners.

The CPNs were not given the authority to control their caseload. Technically they were not obliged to accept all referrals, but in reality they did. We were told by the CPNs and by other staff, including middle managers, that some GPs contacted senior management if CPNs declined to take a patient on, and that there would then be a managerial instruction directly to the CPN to see the patient. The knowledge that this might happen made the CPNs feel that they had to take on all referred cases. Both Mr Brogan and Mr Dalton denied any knowledge of such instructions. However, we were persuaded that such instructions had been received, though we cannot say which senior managers directly sanctioned them.

Comment

Sadly, efforts to placate primary care were in vain. We were told that local general practitioners seem to hold the service in very poor regard. It seems that the Trust would have done just as well by concentrating its efforts on the severely mentally ill; no doubt GPs would still have had a low opinion of the service, but at least Paul Horrocks might have received a better level of care.

As a consequence of these pressures CPNs' caseloads grew in an uncontrolled fashion. Caseloads of 80 to 120 were the rule. The trend across the country has been for CPNs' caseloads to decrease in recent years, reflecting a greater focus on those with complex and severe problems. Simple numbers of patients do not necessarily indicate burden of work. However, we were persuaded in the light of all the evidence that in December 1998 each of the CPNs was carrying a caseload approximately double of that which they could safely manage. Many of them must have made compromises with clinical standards in order to manage their burden of work.

Comment

CPNs were expected to provide a comprehensive service, invariably as key worker, to severely mentally ill patients, to hold liaison sessions in general practices and to accept direct referrals from GPs. In our opinion it was the role of managers to manage these competing demands on the service. To expect the CPNs to take on work in this fashion was bound to lead to intolerable workload pressures.

Every manager we interviewed confirmed that they were aware that CPN caseloads were excessive. There was little evidence that much effort had been made to deal with the problem prior to December 1998, either by restricting referrals to them or by increasing their numbers or by tackling the retention problem. On the contrary, some managers told us that there had been considerable scepticism that there was a problem at all, and that this view had continued until the outcome of the Internal Inquiry. The excessive numbers of cases were said at the time to be due to a failure of CPNs to close cases, and assertions were made that there was no need to employ extra CPNs. The managers still working within the Trust denied that this had ever been the position. So if managers were convinced all along that CPN caseloads were too high, then no effective action was taken to tackle the problem.

Integrated Community Mental Health Teams

At some time in the late 1990s, there was an attempt to facilitate integrated working between Approved Social Workers (ASWs), employed by Wirral Social Services and CPNs, with a single management structure. As a consequence ASWs were moved into the same office bases as the CPNs. However, this did not happen. The ASWs were answerable to their own team leaders based in social service offices and had strictly controlled caseloads, with a waiting list for assessment. If a CPN needed to secure social work involvement with a patient, the referral had to go to the social services team leader, who may or may not instruct an ASW to take on the case although the ASW might have been sitting next to the referring CPN. ASWs rarely took on the key worker role which led to community nursing team members believing that social workers had a very narrow role, mainly restricting it to finding accommodation and dealing with benefits. Despite ASWs' mandatory training with access to a range of advanced courses, including risk assessment and management, there was no question of them helping out with the CPN burden of work.

Comment

There was a lack of clarity of the role of social workers. Approved Social Workers are trained in working with difficult clients and patients, because they have to undertake mandatory regular refresher courses. ASWs have better training than many other disciplines in working with mentally disordered offenders. They often have particular expertise in working with people with combined psychological, mental health, and substance misuse problems. None of the community nursing staff we spoke to were aware that ASWs have this specific training and that they might have had a particular contribution to make in Paul Horrocks' care as a consequence. The referral letter from Ms Jones being sent to the CPN team leader further compounded the lack of clarity of management arrangements. By his own admission he had taken on the day to day management of the social workers in the absence of the social worker team leader.

There appears to have been an inequality in the respective burdens of work between the CPNs and social workers. This could only have contributed to the increasing disaffection of the CPNs, who were already responsible for high caseloads and who were struggling to gain recognition for the work they were doing.

The Inquiry Team also learned that the preference of local GPs was to refer to a CPN rather than a social worker. This also contributed to the imbalance in caseload. Mrs Breda Dutton, Acting Assistant Director of Social Services, told us that:

"A common view is that the 'medical model' prefers CPNs to act as key worker and that this is reflected nationally. Information from the Mental Health Act Administrator for the period from 1 June 1998 until 31 December 1999 which showed that only 17 patients on CPA had a social worker as their key worker".

Comment

The lack of medical leadership, together with a demoralised CPN service, where professionals had little or no opportunity to work out their respective roles and functions, led to a 'Babel-like' situation where there was no common professional language. This appears to have led to inter-disciplinary tension (rather than multi-disciplinary harmony) and a loss of cohesion. One of the consequences of this was a lack of informal and creative case discussion, and little peer support. These are seen elsewhere as significant and important components of an effective service.

Social Network Therapy

The Social Network Therapy (SNT) service further illustrates the lack of attention to basic principles of team working and service planning. None of the Inquiry Team had ever heard of SNT before. It was evidently developed in Canada. A group of staff and managers travelled to Toronto in about 1990 to see SNT in action. The underlying concept is that improvements in the social networks of patients protects them from relapse and improves their functioning.

A service was set up on the Wirral, employing trained professionals from different backgrounds under the management, until recently, of the Therapies Directorate. It is now well recognised that care delivery systems don't necessarily translate in different countries; for example, the advantages of Assertive Community Treatment, which were convincingly demonstrated in the USA, have not been demonstrated in the UK. This was less well recognised 10 years ago. However, the SNT service operated in complete isolation from the other community services. SNT therapists were not based in CMHTs, did not have access to case notes, and there was no forum for them to review cases with other involved professionals. The SNT therapists actually functioned as over qualified support workers. However, everyone recognises the need for support workers to have contact with other professionals. It was difficult for SNT therapists to phone CPNs. Neither had mobile phones at the time and both were busy much of the time in the community. The arrangement was not appropriate when it was set up 10 years ago, and it is still inappropriate.

Comment

It is astonishing that it took a homicide before any manager realised that the SNT service was unsafe and that something needed to be done about it. Social Network Therapy was not integrated within the service, with workers apparently having no access to histories of patients/clients. This was completely contrary to the basic principles of risk assessment and management.

The Medical Workforce and Use of Locum Doctors

Wirral Community Healthcare NHS Trust was confronted with an extremely difficult problem because of the low number of substantive Consultants in post. Consultant Psychiatrists can hand over quite a significant part of their work to other staff, especially senior nurses.

Comment

We were presented with no evidence that any effort was made to re-assign medical tasks, but in fact this would probably have been unrealistic in the light of the turnover and poor morale in the nursing workforce.

However, Consultant Psychiatrists have a particular role under the Mental Health Act which cannot be taken over by other staff. Only doctors can prescribe. There is a national shortage of trained Consultant Psychiatrists, and young psychiatrists are tending to opt for less stressful sub-specialities than general adult psychiatry. In a difficult recruitment environment, the Wirral was unable to compete with areas where there were fewer vacancies. Advertisements for Consultants drew little interest.

The Trust had little option other than to employ locum Consultants. The rules regarding the employment of locums were designed for circumstances where vacancies are short-term. Unfortunately the Wirral is one of many services which carry vacancies for many years. There is then a choice between a continual turnover of short-term locums or the long-term employment of a locum. Short-term locums are usually qualified Consultants making extra money during annual leave. Long-term locums are usually either retired Consultants or, more commonly, doctors with long experience in psychiatry who, for one reason or another, have been unable to meet the criteria for appointment to a substantive Consultant post.

There has been an increased awareness in recent years that locums' performance must be monitored and that they should be supervised appropriately. These matters have been subject to Department of Health guidance (though we recognise that this DOH guidance is difficult or impossible to follow in its entirety in the recruitment environment prevailing in mental health). Paul Horrocks could not be singled out as requiring particular care when he was handed over to Dr Elhibir, because there had been two previous changes of Consultant, and neither of the previous Consultants had any clear awareness of his case.

For some years Dr Al-Bachari took a supervisory role with Dr Elhibir, and they held a joint team meeting once a week. This was a sensible and appropriate arrangement. However, both Dr Al-Bachari and Dr Elhibir told us that this was an informal arrangement, made between themselves. Professor Wilson, on the other hand, believed it was part of a formal system of supervision, which applied to all locums. Dr Elhibir told us that since Dr Al-Bachari had left the service in September 1999 he had had no supervision as he now shared a patch with two other locums. Professor Wilson told us that Dr Mahmood now supervised Dr Elhibir as a formal arrangement, which was surprising as Dr Mahmood told us that Dr Elhibir was reasonably good, liked by his patients, and did a reasonably good job. But he did not follow up his clinical work because his own role within the Trust changed. We were later shown a letter dated 18/3/99 from Steve Morgan (acting Clinical Director at the time) to Dr Mahmood, asking him to supervise Dr Elhibir.

Comment

We conclude that the Trust's system for supervising the performance of locums was so poorly organised and monitored as to be ineffective.

Recruitment of Consultants - "The Bubble"

By February 2000 the Trust had recruited a number of substantive Consultants (though Birkenhead, which had one substantive consultant in 1998, now had none). This welcome improvement in the Trust's recruitment record in general adult psychiatry appeared to be the result of a strategy devised by Professor Wilson. As it was described to us, there were a number of elements to this strategy, but there were two key components. Firstly, as each consultant post was advertised, the duties were adjusted so that the new appointees covered a much reduced population. Secondly, each Consultant was offered a salary enhancement for special responsibilities. The strategy was followed without a concomitant increase in the number of consultants, though it was hoped that this would eventually follow. This meant that that part of the population no longer covered by the new consultants, the so called 'bubble', had to be covered by one or more of the existing, overly stretched teams. In practice the result was an increase in the size of the populations covered by the Birkenhead teams. Whether or not it was foreseen, the outcome was that attractive posts were created in the areas of lower need by increasing the already severe pressure in the teams covering the area of greatest need. It was Professor Wilson who described this plan as *"the bubble"*.

Comment

The Inquiry Team does not believe that this was an appropriate solution. We believe that this strategy left the service in Birkenhead in a precarious state and that it created conditions which remained unsafe when we took evidence. We were relieved to hear that the new Clinical Director, Dr Ian Davidson, had made it clear that he did not agree with the plan, and that steps had been taken to change matters.

When we discussed the plan with Professor Wilson, he felt there was no other way to deal with the Trust's recruitment problem, given the severity of the situation. We believe that there were a number of alternatives to this plan, and that the consequences of pursuing it should have been foreseen. We believe that the bubble plan contributed to the present tragic incident.

It has been asserted that we misunderstood the 'bubble plan', but the details were confirmed by a number of witnesses. It has been said that the new Consultants chose to work in affluent areas, and that the effects on the Birkenhead service were out of the managers' control. We believe that it was inevitable that such a plan, pursued without an increase in consultant posts, was bound to have a detrimental effect on the most deprived area, i.e. Birkenhead.

We were told that the Trust Board had no knowledge of the bubble plan. We felt that they should have either noticed its effects or been told about it. This plan created a gap between the Trust's public stance and the realities within the service. On the one hand, the Trust publicly stated that improving general adult services in Birkenhead was its highest priority, whilst on the other hand, a plan was followed in which increased pressure on services in Birkenhead in the short-term was the de facto price paid for improved consultant recruitment.

Birkenhead South Community Services

The adult mental health services in Birkenhead were unco-ordinated and communications even within 'teams' were exceptionally poor. We were told that the CPN Team Leader was also managing the CPNs whilst holding a large caseload of his own. Senior managers recognised that there were difficulties in recruiting medical staff to this team but nonetheless the Birkenhead team was ever more over stretched when Consultants were recruited to work in other better resourced posts serving more affluent areas. Social workers in the same team could not be easily accessed and had protected caseloads. The CPNs did not understand that social workers could have a role beyond finding accommodation, and this reflected the lack of any true multi-disciplinary team working.

The Care Programme Approach

The Care Programme Approach (CPA) was introduced in the early 1990s to make sure that care of the mentally ill is well co-ordinated and that patients do not get lost to follow up. It aims to promote good practice. In other words, it was designed to avoid exactly the type of failings which arose in Paul Horrocks' care. Mr Barry Williams told us that in 1997-8 the CPA was fully implemented in the Trust and all relevant staff had been trained in its use. There were systems to ensure that CPA reviews occurred when they were meant to. However, on direct questioning he accepted that in fact there was nothing like "CPA type team work"' in operation on Wirral at the time. He also confirmed that it was quite impossible for the CPNs to carry out their responsibilities as CPA key workers in view of their high caseloads. We have seen that the CPA reviews failed to occur in Paul Horrocks' case, even when requested by the key worker. The Trust operated time consuming IT systems including a variety of cumbersome paper systems, including the "fully implemented" CPA. The Care Programme Approach was designed to improve communications and co-ordination of services. It is supposed to prevent the problems created by fragmented services where no one takes control in the delivery of the service.

Comment

Despite the Internal Inquiry being satisfied that CPA systems were *"well established and met national standards"* it was acknowledged that in the case of Paul Horrocks it was not effectively monitored.

Managers claimed CPA was fully operational, whilst acknowledging that there had been no impact on patient care at all. Very few CPNs or GPs attended CPA meetings because of competing demands on their time. This meant that, even where CPA reviews took place, there could be an incomplete view of the situation, and therefore inaccurate assessment of risk.

CHAPTER 8 PROFESSIONAL ACCOUNTABILITY

The responsibility of the key professionals for their own failings is significantly mitigated by the fact that they were working under intolerable conditions. However, no matter how difficult working conditions become, professionals cannot abrogate their responsibility for maintaining safe practice. All of the professionals involved with Paul Horrocks in the year leading to the homicide could be subject to a degree of criticism. They all held pieces of a jigsaw which should have revealed an impending disaster. At no point were all their views brought together as they should have been in the spirit of team working.

The Community Psychiatric Nurse and Key Worker

Mr Quick failed to draw attention to his lack of contact with Paul Horrocks, and in failing to do so, induced complacency in other professionals. He accepted the key worker role without ensuring that he had an adequate knowledge of the patient's background and level of risk. He did not discharge his responsibilities to Paul Horrocks appropriately. However, he had been a rehabilitation and resettlement worker who was moved into generic CPN work without training, late in his career. He was downgraded, albeit without loss of salary, but also without any change to job description or supervision arrangements. He was obliged to accept without question referrals from both the Consultants and from GPs. His large caseload was unmanageable. Struggling to cope with his patients, he understandably, but mistakenly, assumed that Paul Horrocks was being monitored by Simon Bridges. Less understandably, he did not liaise properly with Mr Bridges or Dr Elhibir.

The Social Network Therapist

Mr Bridges worked in an isolated and inappropriate role, disconnected from other professionals. His lack of clarity over his role misled other professionals as to the degree to which he was monitoring Paul Horrocks' mental state and compliance with medication. Mr. Bridges conscientiously carried out a confused role. He functioned as an isolated support worker and he didn't utilise his nursing skills. He made misjudgements. For example, he assumed that Paul Horrocks' relationship with Carol Houghton was a healthy one and he therefore encouraged it. In fact it was a pathologically violent relationship, built around alcohol and rendered more dangerous by Paul Horrocks' delusional beliefs.

Consultant Responsibility in 1998

Dr Elhibir struck us as a sincere and hard working doctor. He is, however, palpably out of his depth in the role of Consultant Psychiatrist. He displayed to us a lack of understanding of risk assessment. His lack of qualifications in psychiatry should have alerted medical managers to his potential weakness with difficult cases. Instead, he was given a heavier caseload than any of his substantively appointed colleagues. He worked in a team that was generally under resourced and in an area with high levels of deprivation and psychiatric morbidity. Dr Elhibir did not ensure that he personally reviewed Paul Horrocks following his implausible undertaking to resume oral medication. Paul Horrocks should have been prominent in Dr Elhibir's awareness, as he was the only patient on his caseload who had been detained under Section 37.

Social Worker and Key Worker until 1998

Ms Jones recognised that Paul Horrocks' mental health was deteriorating and took appropriate action to bring the professionals together. In the normal course of events Ms Jones would have transferred Mr Horrocks to a new social worker when he moved from Knowsley Road, out of her catchment area. When her offer, in her letter dated 4 June, to facilitate hand over to Wirral social services was not taken up, good practice might have been to find out why the case hadn't been picked up by another social worker. She may well have become frustrated in the face of the difficulties of the services on the Wirral. In hindsight, it might have been appropriate for Ms Jones' supervisor, Ms Glenys Heath, Team Leader Cheshire Social Services, to have taken a more positive role for facilitating reallocation out of the area given the concerns of Ms Jones.

CHAPTER 9 THE INTERNAL INQUIRY

In accordance with the terms of reference for this Inquiry, we were asked to comment on the previous Internal Inquiry completed by the Trust. (The terms of reference for the Internal Inquiry can be found at Appendix 3). In assessing the quality of this report we were aware that the Internal Inquiry Team had access to less information than we did, and that the report was prepared against a tight time schedule. One could not reasonably expect a high quality document. However, we find this report inadequate.

The membership of the Panel was agreed as: Trust Chairman, Medical Director, Acting Director of Mental Health Services, a Wirral Health Authority Non Executive Director and Wirral Health Authority Commissioning Director. The composition of any Internal Inquiry Panel is usually agreed with the Health Authority and the Regional Office. This Panel did not include a practising clinician in adult mental health. The medical member was Professor Wilson. All other members of the Panel who we spoke to explained that they relied on his opinion on clinical matters. Although Professor Wilson holds a Certificate of Completion of Specialist Training in general adult psychiatry, he works in the field of mental health services for the elderly.

Comment

In our opinion, arrangements should have been available for a general adult psychiatrist from Chester to attend the Panel, or for a general adult psychiatrist from another Trust to be consulted.

We were fortunate to have access not only to the report of the Internal Inquiry Panel, but also minutes of all their interviews, the documents prepared for them and the minutes of the subsequent Implementation Group.

The findings were presented in line with the agreed terms of reference. The supporting evidence was difficult to find because it was set out in 14 appendices. These included detailed minutes of meetings setting out, amongst other matters, evidence from clinical staff and the catering arrangements. The report was brief with findings of fact rather than critical analysis. Some of the important findings are implied rather than clearly stated. The subsequent 'actions taken' reports do not correspond to the findings of the Panel.

We feel the report was not even handed in its criticism of staff. Mr Quick and Mr Bridges were severely criticised. We believe that the report ignored the conditions they were working under as mitigation for their inadequacies. Dr Elhibir, however, was not criticised, despite evidence within the report which suggests that his management of the case was of poor quality. Dr Elhibir admitted to the Internal Inquiry that he did not review Paul Horrocks' case notes on taking over his care. This was a major omission, as he could not have made a proper assessment of risk, which is the role of the Consultant, above all other staff. Dr Elhibir believed that the danger of further violence from Paul Horrocks had diminished over time, simply because previous events were remote.

This statement was telling as it was entirely wrong as a general principle and was proven to be wrong by events. A patient who has been violent during one episode of illness is likely to be violent again on relapse. The relapse leading to the homicide was only Paul Horrocks' second episode of florid illness and Dr Elhibir's assessment did not reflect a level of understanding expected in a Consultant.

The report suggests that Paul Horrocks' problems at the time were due to alcohol misuse and that he hadn't recently shown psychotic symptoms. This important but entirely erroneous finding conflicts with clear evidence of psychotic relapse in the case notes, as well as other evidence, such as Mr Quick's evidence to the Internal Inquiry that Paul Horrocks reported *'voices and people trying to control him on occasions'.*

Comment

We cannot understand how any psychiatrist could believe that Paul Horrocks' violence was primarily due to alcohol misuse rather than psychosis. It is stated in the report that this was also true of the assault on his stepfather, mother and a police officer. It is also said that the stepfather provoked that assault. Even a cursory inspection of the case notes shows that this view is unsustainable and inaccurate. Most studies show that between 30% and 50% of young men with schizophrenia have a substance misuse problem, two thirds of these being alcohol misusers. Alcohol misuse is therefore very common in this patient group. Alcohol is frequently implicated in crimes of violence, but is rarely sufficient in itself to explain that violence. The report gave a clear impression that the homicide was not due to mental health factors. This finding lacked objectivity.

The report was entirely uncritical in its vindication of the Trust's policies and procedures. For example, the statement that the CPA policy was functioning well flies in the face of the realities in Birkenhead. The Trust managers on the Panel, must have been aware that it was impossible for the staff to implement the CPA properly. Every manager we asked confirmed this. Likewise effective clinical supervision was equally impossible in Birkenhead, and managers must also have known this. We heard that the team leader himself had caseload management problems in addition to other responsibilities and therefore many of his arranged supervision meetings were cancelled.

Comment

The Internal Inquiry Panel seemed to have no overall view of the lack of support and clinical supervision in Birkenhead, which had been identified as a difficult area to recruit and retain staff.

The incident occurred within a multi-disciplinary community mental health team, where one could have expected some degree of communication. However this was sadly lacking. Significant information was not passed against the background of an attitude that *"no news is good news"*, a finding which particularly worried the Internal Inquiry Chairwoman. The CMHT included social workers. The Inquiry might have been able to highlight deficiencies in the delivery of services, including those from social services. However the Internal Inquiry, perhaps because of its membership, did not appear to have considered the 'tracking' of Mr Horrocks across the two Social Services Departments (Cheshire and Wirral), or the fact that he was lost to social work following the letter to Mr Sanderson.

Comment

We find that the report lacked objectivity on policy and policy implementation issues. Although some recommendations of the report were sensible, others were bureaucratic and difficult to implement. For example, the policy that patients who are non-compliant with medication should automatically be subject to a CPA review is impossible to implement. Many patients, like Paul Horrocks himself, move back and forth along a spectrum of treatment compliance and much of the business of adult psychiatry is to persuade patients to do things they don't want to do. It must be remembered that 70% of all NHS prescriptions are not taken as directed. The proposed policy was such that staff would have difficulty in carrying it out.

It was noticeable that there was not a single recommendation in the report that was aimed at easing the working conditions of the staff. It was not surprising to find that, despite the report, the service in Birkenhead continued to deteriorate after it was produced.

We were disappointed to learn that many members of staff were not given access to the report.

We were told by one of the Internal Inquiry Panel members, *"it has become clear that the overall structure in place at the time was not conducive to effective service development, delivery and monitoring due in part to the systems, structures and the individuals in post at the time. The service presented was one that was not fully integrated within itself and that a variety of factors increased the pressure on the service and staff working within it. These pressures were identified as, the size of the service, number of locum Consultant posts, caseload sizes, high turnover of CPNs, lack of integrated systems and the number of organisational changes. The range of services was not adequate and an obvious deficit was the number of locum Consultants and the lack of leadership as there was not a clinical director in post all of which led to a pressure on the service especially in Birkenhead."*

Comment

We believe that the recommendations posed by the Internal Inquiry were systems driven rather than addressing the specific pressures on the Birkenhead service such as recruitment of Consultants and the retention of CPNs. We were also told that the recommendations were, *"possibly fairly basic and modest and they were a useful sticking plaster"*.

The Independent Inquiry Team was left with the impression that the Internal Inquiry deflected attention from failures in the adult mental health management system to adequately support its staff and patients.

CHAPTER 10 KEY FINDINGS

1. We find that the main factor leading to Paul Horrocks' fatal assault upon Carol Houghton was that he was suffering an acute relapse of a schizophrenic illness at the time. This was exacerbated by heavy drinking.

2. We find that there were clear risk factors indicating that Paul Horrocks might again act violently in the event of relapse. These should have been recognised by the professionals caring for him. On the other hand, the degree of violence he exhibited could not have been predicted.

3. We find that the care provided to Paul Horrocks was appropriate up until the time when Dr Sullivan stopped being his Consultant. From that time, the overall quality of care was inconsistent and sometimes inadequate. Not all staff performed poorly, and there were periods when the quality of care improved, only to worsen later. There was a long period leading up to the homicide during which Paul Horrocks' mental health deteriorated. The quality of care was poor at this time owing to the cumulative and combined effects of poor co-ordination of care, inadequate communication, repeated changes of personnel, poor handover procedures and a superficial approach to risk assessment and management.

4. We find that this homicide might have been prevented if the quality of care had been within acceptable limits. In particular, it is possible that Carol Houghton would not have died if a more assertive approach to treatment had been taken after the meeting on 20 May 1998.

5. Although we have set out specific criticisms of the performance of individual staff in the run up to the homicide, we do not believe that it is appropriate to lay blame for what occurred upon these individual professionals. The effects of failings in care were cumulative. Those professionals involved in December 1998 were not necessarily the least diligent of all those involved. Furthermore, the mental health services in Birkenhead had been subject to poor management over a long period of time. This had created an environment where staff were so over burdened that it was impossible for them to conscientiously carry out their duties to an adequate standard. The poor quality of management of the mental health services in Birkenhead was a major factor leading to the homicide.

6. We recognise that the Wirral and West Cheshire Community NHS Trust inherited severe problems when it became responsible for all psychiatric services on the Wirral. We also recognise that this was bound to lead to hard choices in order to resolve those problems. However, we find that inappropriate decisions were made after the merger of mental health services on the Wirral which allowed conditions in the Birkenhead sector to deteriorate to the point where the service became unsafe. The most important example is what was described to us as the 'bubble' plan.

7. We find that the internal investigation was of poor quality, which had the effect of making scapegoats of Mr Quick and Mr Bridges, and deflected criticism from managers. The internal investigation failed to achieve its main objective, namely to recommend action which might prevent a further similar tragedy. On the contrary, the deterioration in the service in Birkenhead continued after the internal investigation.

8. We find that Wirral Social Services provided a very limited service to people with mental illness. Their level of activity within CMHTs was so low that other mental health professionals lacked an understanding of the scope of psychiatric social work. We find that continued social work involvement with Paul Horrocks might have played an important part in preventing his ongoing deterioration. The level of activity by Wirral Social Services in Birkenhead CMHT was too limited to allow us to assess the effectiveness of the services they offer.

CHAPTER 11 RECOMMENDATIONS

1. Best practice models from elsewhere in the United Kingdom should be used to inform the development of an integrated comprehensive mental health service. This should be achieved through the establishment of a Joint Commissioning Board, drawing on a pooled budget.

We recommend that Wirral Health Authority, Wirral Social Services and the local Primary Care Groups should rapidly develop a full Joint Commissioning Board.

2. We have stated that the situation in the Birkenhead sector deteriorated between the time of Carol Houghton's death and February 2000. There were no substantive Consultants in February 2000, whilst there was one in post in December 1998. The sector burden of work had increased under the 'bubble' plan.

We recommend that remedial action should be taken as a matter of extreme urgency, to ensure that conditions in the Birkenhead mental health service are raised to an acceptable standard in the light of all expectations of a modern mental health service.

3. We accept that the appointments of Mr Stephen Johnson, Director of Mental Health and Dr Ian Davidson, Clinical Director, have brought to the Directorate experience and managerial expertise which have been sorely lacking in the past. We recognise that the appointment of several Consultants may ease recruitment difficulties in the future. However we believe that senior managers still need to take account of the effects that the past problems have had on the service. In interviews with the Inquiry Team, senior managers repeatedly contrasted the situation in 1998 with the position in February 2000. We understand that new members of staff are now in the senior management posts in the Directorate. We believe that further work needs to be done to resolve the problems that we have identified and new staff need to be supported in their role.

We recommend that service developments should take place across the Wirral and West Cheshire to address the serious deficiencies that have been highlighted in this report.

4. In order to effect improvement, the service needs good quality leadership at all levels. This requires a fundamental change in the style of management and in the level of expertise of managers. Managers need to be trusted by staff and in return, staff need to be listened to, feel valued and given encouragement. Given the history of the service, this will not be easy to achieve without some external support. We believe that with the new appointments of the Director of Mental Health, the Clinical Director and other senior managers in the Directorate, the leadership and management capacity is changing for the better. The Director of Mental Health told us that, *"the task is a significant one, the agenda is huge. Things will not improve overnight"*. We recognise that whilst he feels supported by his senior management colleagues, all the staff in the Directorate need further reassurance.

We recommend that the Trust should establish a programme of change management to take account of the findings in this report and the changing national mental health agenda, which should include individual development plans for all senior managers.

5. The configuration of management of mental health services in the North West is presently under review, and we have no knowledge of the options which are being considered for Wirral and Cheshire. However we feel that present problems in the mental health services should be resolved prior to the Trust taking over any other mental health services.

We recommend that the Wirral and West Cheshire Community NHS Trust should not take over adjacent mental health services unless it can clearly demonstrate that it has fully resolved its present problems.

6. We have only investigated the Birkenhead sector. From the evidence we have heard it seems likely that there are problems in other parts of the Trust's adult mental health services. Such problems cannot be dealt with piecemeal.

We recommend that Wirral Health Authority carry out a review of the whole adult psychiatric service of Wirral and West Cheshire Community NHS Trust, including both clinical and managerial issues. Following this review they should set clear critical targets for improvement against specific deadlines, based upon their findings and our recommendations.

7. Wirral Health Authority should establish a short-term programme to ensure that the level of funding for the service rises above the national average, in order to allow for the cost of remedial action. There should also be an internal bench marking exercise and action should be taken to ensure that resources are distributed according to morbidity in the various sectors. This should be achieved through increases in total resources rather than transfer of resources between sectors, which would exacerbate existing problems.

We recommend that Wirral Health Authority should commission a bench marking exercise. This should compare the level of funding for the service as a whole with similar areas in other parts of the country, adjusted for factors such as deprivation.

8. There is a need for agreement on how mental health care should be shared between primary and secondary care. This should include investigation of liaison arrangements to support primary care, and multi-disciplinary training plans, incorporating, if possible, General Practitioner Post-Graduate Education programmes. Parallel with this process we support the continuing work of the North West Mental Health Development Centre (NWMHDC) in developing multi-disciplinary CMHTs, including questions of staffing levels, caseload management, referral systems, skill mix and integration of social workers, occupational therapists and psychologists into the CMHTs.

We recommend that Wirral Health Authority, Wirral and West Cheshire Community NHS Trust and the Chief Officers of the Wirral PCGs should establish a working group to develop protocols between primary care and mental health services.

9. **We recommend that the Trust should:**

a) Undertake a thorough review of all clinical and operational policies to ensure that these are logical and routed in good practice and that they support clinical practice rather than undermine staff.

b) Undertake a review of risk management and risk assessment procedures. There should be consideration of the introduction of a validated standardised risk assessment instrument to be used by all staff. A rolling programme of risk assessment training should be introduced and made mandatory for all permanent clinical staff including Consultant Psychiatrists, Psychologists and Occupational Therapists.

c) Conduct a review of the liaison psychiatry service functions, its clinical leadership and its relationship to the rest of the service.

d) Ensure that the Social Network Therapy service becomes part of the generic workforce. It has been dispersed to the CPN office bases since the publication of the Internal Inquiry. However, in our opinion, it is a failed experiment, which should be abandoned.

e) Commission a comprehensive external expert review of the untoward incident audit system, including suicide audit. The untoward incident audit should shift in focus from numerical analysis towards objective assessment of quality of care.

f) Develop a standing audit of caseload and case mix for all staff working in the community.

g) Organise a comprehensive review of record and IT systems, in order to reduce staff time spent on paper work and in order to facilitate good communication. It is likely to be necessary to commission new systems, as the existing systems are ineffective and incompatible with each other.

h) Ensure that all patients receiving enhanced CPA are subject to regular and audited multi-disciplinary review. CPA systems must reflect reality. In the light of difficulties evident in continuity of care, the Directorate should consider the use of mandatory rolling case summaries for all patients on enhanced CPA. If such a system is not developed, alternative methods of keeping track of patients' care must be developed.

i) Ensure that all locum Consultants have named supervisors. The supervising Consultant should be responsible for ensuring that regular supervision occurs. Supervision should focus on identifying and managing high-risk patients.

j) Ensure all locum Consultants who are not qualified to hold a substantive Consultant post in the UK have a development plan agreed with the clinical director. For example, Dr Elhibir would have benefitted from a secondment to a Regional Forensic Psychiatry Service.

k) Ensure that there is an obligation on Consultants leaving post to hand over high-risk patients through a written summary.

l) Ensure that there is a review of the Birkenhead caseload in order to identify high-risk cases.

10. We recommend that Health and Social Services senior managers must ensure that:

a) All CPA key workers have caseloads which are of an appropriate size to allow them to discharge their responsibilities appropriately.

b) All staff, including staff who are supervisors, have protected time to allow for regular supervision which informs and improves future practice.

c) Training programmes on risk assessment and management should be delivered to multi-disciplinary teams.

Appendix 1: Written Documentation

Paul Horrocks' Case Notes

General Practitioner records

Clatterbridge Hospital records

Community Psychiatric Nursing records

Social Network Therapy records

Arrowe Park Hospital records

Scott Clinic records

HMP Liverpool medical records

Cheshire County Social Services records

Wirral Health Authority

Improving Mental Health on the Wirral – A Strategy 1995

The Vision - NHS Adult Mental Health Services on Wirral

Wirral & West Wirral Cheshire Community NHS Trust

Internal Untoward Incident Report

Untoward Incident Review Group 18 February 2000

Notification of Serious Untoward Incidents

Care Programme Approach Policy

Mental Health Act Commission

Reports of visits 5/6 June and 12 December 1997, 31 July 1998, 25/26 February 1999

Metropolitan Borough of Wirral

Report of unannounced inspection to 4-6 Knowsley Road 15/16 July 1999

Wirral Community Health Council

Report of visits to Clatterbridge Hospital mental health wards

Crown Prosecution Service

Court reports

Merseyside Police

Witness statements

Appendix 2 List of witnesses

Dr M Al-Bachari	Consultant Psychiatrist
Mr R Bennett	Social Worker
Mr S Bridges	Social Network Therapist
Mr A Brogan	Formerly General Manager Mental Health Services
Mr P Cronin	Chief Executive Wirral Health Authority
Mr S Dalton	Chief Executive Wirral & West Cheshire Community NHS Trust
Ms P Davies	Ward Manager Arrowe Park Hospital
Mr and Mrs H De-Rooy	Residential Care Home Owners
Dr I Elhibir	Locum Consultant Psychiatrist
Mr M Gailey	Liaison Psychiatric Nurse
Ms G Heath	Social Work Manager
Dr J Higgins	Consultant Forensic Psychiatrist
Mr P Horrocks	Subject of the Inquiry
Mrs E Hoskins	ex Chairman Wirral & West Cheshire Community NHS Trust
Mrs Houghton and family	
Ms K Jones	Social Worker
Mr S Johnson	Director of Mental Health Services
Dr R Mahmood	Medical Director Wirral Hospital NHS Trust
Dr J Mawdsley	General Practitioner
Dr J McCarthy	Specialist Registrar Forensic Psychiatry
Mr N Morris	ex Commissioning Manager – Mental Health
Mrs P Mowatt	Staff Nurse Arrowe Park Hospital
Dr S Palmer	Senior Psychiatric Registrar
Mr C Quick	Community Psychiatric Nurse
Mr M Sanderson	CPN Team Leader
Mr M Sinnott	Locality Manager at the time of the incident
Mr A Styring	Directorate Manager Old Age Psychiatry
Ms C Warriner	Mental Health Act Administrator
Mr B Williams	Senior Nurse/ CPA Co-ordinator
Ms L Wilkinson	Community Psychiatric Nurse
Professor K Wilson	Medical Director
Ms B Woodworth	Senior Nurse Liaison Psychiatry

Appendix 3 Internal Inquiry Terms of Reference

1. Examine all the circumstances surrounding the treatment and care of the patient by the mental health services in particular:-
   (a) his assessed health and social care needs
   (b) his assessed risk of potential harm to himself or others
   (c) the appropriateness of arrangements to manage identified risks
   (d) any previous psychiatric history
   (e) the number and nature of other serious incidents
   (f) the adequacy of discharge planning.
2. Examine the extent to which his care corresponded to statutory obligations, guidance from the Dept of Health and local policies.
3. Examine the extent to which the prescribed care plan was:-
   (a) effectively delivered
   (b) complied with by the patient
   (c) monitored by Key Workers/ Primary Nurses/ Doctors
4. Examine the adequacy of the collaboration between agencies.
5. Identify any deficiencies in the quality and delivery of care.
6. Make recommendations for the future delivery of care including admission, treatment, discharge, and continuing care to people in similar circumstances so that as far as possible, harm to patients and the public is avoided.
7. To prepare a report and make recommendations to both the Trust and the Health Authority regarding future care.

Appendix 4 Background Reading

Dept of Health 1990 The Care Programme Approach HSG(90)23/LASSL(90)11

Dept of Health and Home Office 1991 Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services chaired by Dr John Reed

NHSME 1991 Criminal Justice Act 1991 Mentally Disordered Offenders Health Service Guidelines

Dept of Health 1993 Caring for People with Severe Mental Illness, Information for Psychiatrists

Dept of Health 1993 The Health of the Nation Key Area Handbook - Mental Illness

Dept of Health 1993 The Health of the Nation - Mentally Disordered Offenders

Dept of Health 1994 Introduction of Supervision Registers for Mentally Ill People HSG(94)5

Dept of Health 1994 Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94) 27

Dept of Health / Home Office 1994 Report of the Dept of Health and Home Office Working Group on Psychopathic Disorder. Chairman Dr John Reed

Dept of Health 1995 Building Bridges a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people

Dept of Health 1996 The Health of the Nation - The Spectrum of Care. Local Services for People with Mental Health Problems

Dept. of Health 1999 A National Service Framework for Mental Health

HMSO 1994 and 1999 Code of Practice Mental Health Act 1983

Dept. of Health 1999 Effective Care Co-ordination in Mental Health Services A Policy Booklet

Dept of Health 1999 Safer Services National Confidential Inquiry into Homicides and Suicides by People with Mental Illness

Dept. of Health 1999 Still Building Bridges. The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management

Richard Jones 1999 Mental Health Act Manual Sixth Edition, Sweet & Maxwell

Zito Trust 1996 Learning the Lessons 2nd Edition Mental Health Inquiry Reports published between 1969-1996 and their recommendations

Peay Jill, 1996 Inquiries after Homicide Duckworth

UKCC 1998 Guidelines for Records and Record Keeping